AYURVEDA IN TRANSLATION: ONE CROSS-CULTURAL NARRATIVE

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ABSTRACT

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by James Battle

This thesis presents data and findings from ethnographic fieldwork conducted in summer 2004 at a retreat center in Northern California by conducting limited observations and open-ended semi-structured ethnographic interviews with students and the teacher. The Alta Mariana Center draws on South Asian healing traditions to teach potential California practitioners. The following research questions were posed; how do cultural constructions of health, illness, diet, and healing affect/effect cross-cultural cognition within a shared learning space? What have been the life experiences of the workshop attendees that led them to the point of studying Ayurvedic medicine? How is Ayurveda presented to Western students by South Asian and American teachers? Are there any epistemological gaps? How are they bridged? Is the resulting "product" Ayurveda? Social parallels with Tibetan medicine are discussed.

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Chapter One

Introductions, Settings, and Methods

Cultural dissonance in Ayurvedic pedagogy has fascinated me since my time as a student of one of the first South Asian professors of Ayurveda to teach in the United States. Of the class of fifteen in the Ayurveda program in 1983 at the Institute of Traditional Medicine in Santa Fe, New Mexico, only three of us went on to practice and teach Ayurveda. Our conversations usually centered on why learning Ayurveda, a concept clearly articulated by our professor, Dr. Vasant Lad, seemed to go over the heads of most of our cohort. The answer continued to elude me for years, rendering the question perennially present.

One of the three successful practitioners, a close friend, became an acupuncturist who continued using some Ayurvedic formulas in his practice. He wanted a more disciplined pedagogy and its fruits in the form of legal protection and professional status, all of which acupuncture licensure in California provides.

In winter 1983, I made the first of several trips to Trinidad and Tobago. I found in Trinidad a sizeable East Indian community, that, although devoid of classical Ayurvedic pedagogy, kept some of its forms alive, judging by the form and content of the herbal wines (*arishtas* and *asavas*) sold throughout the island. This was the beginning of my interest in Ayurveda as a medical diaspora, in this particular case, the result of Indian importation to the West Indies by the British in the 19th century.

In 1990, visiting Ayurvedic research institutions, hospitals, and colleges in Sri Lanka, I first experienced Ayurvedic practice outside of its Indian and Hindu

contexts. The Anti-Tamil Riots of the mid-1980s had such an effect on the Government College of Indigenous Medicine, that the Department of Siddha (Tamil) Medicine was disbanded, its faculty and students dismissed. However, the College kept the Tamils' medical dispensary. It was in Sri Lanka that I began to question the relationship between power, politics, religion, culture, and the tractability of medical praxis and development, clinical efficacy notwithstanding. Therefore, Ayurveda is viewed in this work as a medical diaspora, with concomitant cultural cosmologies and cosmogonies constructed by history, power, hegemony, and syncretic reconfiguration.

During years of private practice and public teaching, I found other cultural incongruities extant in the interface of Ayurvedic epistemology and Western cultural assumptions. Fitting Ayurvedic notions of time as healer with Western notions of time as money, each with their own set of therapeutic practices and expectations, proved difficult to accomplish. Ayurvedic concepts of time are extended, time itself a healer that cannot be rushed. In the "time is money" framework of contemporary practice in the United States, time is contracted, abbreviated. What I mean by notions of time as healer and time as money conflate into the contemporary pragmatics of capitalism, professionalism, and, more to our case here, Ayurvedic pedagogy, praxis, and authenticity.

In exploring this issue, I was interested in learning how Ayurvedic theory and praxis were communicated and, whether Western constructions of health, illness, healing, and the body influence student cognition within this cross-cultural learning space. To this end, I inquired into what life experiences have led these students towards an understanding of "other" ways of viewing health and healing, and, how it assisted their

comprehension of Ayurvedic epistemology. How do these understandings interconnect with the realities and aspirations of the market, professional status, and the legal protection that professional status inheres? Does social capital reinforce or circumvent these realities? Underlying these questions is the assumption of human agency, an assumption this research considers essential to investigate. What roles do social capital, legal and biomedical indeterminacy, and human agency, play, if any, in the creation of "liminal" spaces of cultural redefinition and epistemic change, as observed and heard in this workshop?

My approach in conducting this research is therefore interdisciplinary in nature, utilizing concepts, methods, and discourses from history, anthropology, and the behavioral sciences. This approach is in full agreement with Kleinman (1980) in that there are overlapping areas between medicine, psychiatry, anthropology, sociology, history, and public health, which Kleinman avers is an "unmarked borderland" (1980:xi).

Literature Review

Theoretically, this work is in part influenced by Robyn Kliger's (1994) work on somatization, sharing and employing the view "that the body is employed transculturally as a vehicle for the communication of states of mind and emotionality" (1990:60). This ascription to the body offers a way of examining Ayurvedic learning in the West, using the body as trope for transcending essentialized cultural boundaries. Scheper-Hughes' (1991), following Mauss (1950) trope of somatization as a form of "body praxis" – an historical, social, and cultural product shaped and inscribed by the mind onto the body, informing their communicative norms as a totality. The local specificities of these

localized somatic memories would require, theoretically, new forms of pedagogy and cognition in the process of learning and practicing, say, Ayurvedic medicine in new spaces. Is it possible that Ayurveda taught, learned, and practiced in new spaces will itself become a "new" Ayurveda? What, then, will be considered the "authentic" or "correct" Ayurveda? Will social, political, and economic capital decide the winner? This work takes up these questions in later chapters.

A growing body of ethnographic work has been written on modern manifestations of Ayurveda and its interface with the West, such as Leslie (1992, 1963), Crozier (1970), Cohen (1998, 1995), Alter (1999), Obeyesekere (1992), Trawick (1992), Langford (2002, 1995), Baer (2003). Leslie (1992, 1963) examined the political representations and essentialist rhetoric used by nationalist politicians in both India and Sri Lanka to simultaneously legitimate and marginalize Ayurveda during the pre- and post-independent years. Trawick (1992) and Obeyesekere (1992) using descriptive and comparative methods, illustrate how Ayurveda is practiced in contemporary South India and Sri Lanka, respectively. Jean Langford (1995) examined contemporary urban Indian Ayurvedic epistemology and praxis within the context of political, biomedical, and hegemonic perspectives. Her (2002) ethnography charts the development of modern Ayurveda from the British colonial to the postmodern present, including its recent movements to the metropoles of the West.

There is, however, no ethnographic work extant concerning student/practitioner epistemology and pedagogy in Ayurveda. More exactly, only four works examining practitioner epistemic and ontological development exist in the entire field of

complementary and alternative healing. This I found intriguing given the growth of CAM practices and the increased amount of consumer spending attendant to this phenomenon. To this end, I initiated this research project.

Methods

As this was an Ayurvedic workshop geared towards health care practitioners, I was interested in interviewing people with a broad range of experiences and perspectives. I delved into meanings of health, illness, and healing, asking informants whether or how they had changed over the course of their lives and how Ayurvedic approaches translated into their lives and work. I had my informants draw a map of their lives, highlighting those moments when their concepts of health, illness, healing, the body, and diet changed significantly or began to shift in a certain direction. I asked them what changes in awareness were experienced during these moments and what courses of action were taken.

I then enquired as to whether or not their changed awareness and subsequent action had taken them outside the biomedical paradigm. Did it create openness towards studying a different healing system? I asked them to describe their learning experiences with Ayurvedic medicine, what aspects they enjoyed, what topics they found difficult to understand. As practitioners, I was also interested in finding out how, to their satisfaction, were they able to incorporate, or when necessary, translate Ayurvedic concepts and practices into a local knowledge base suited to both their clients' nascent expectations, and their own individual practitioner style.

In this fieldwork, I employed participant-observation, as well as semi- and unstructured interviews. Questions were asked both in and out of class. Conversations during meals and free time proved quite valuable and enriching. However, while research questions, in their objective form, may imply a certain learned naïveté, even liminality, I found myself at an epistemological crossroads during much of my fieldwork.

Measuring my degree of participation in this project as an anthropologist, former Ayurvedic and student, practitioner and lecturer, was virtually impossible. However, what can be said is that these current and former roles informed my fieldwork for the better by allowing me to analyze and observe from different angles, applying insights and perspectives that no one role could confer. This fieldwork experience demonstrated that posing questions in class was an advantageous method of eliciting information and clarifying data.

For example, even the act of using a notebook, which might have been rendered invisible as a commonplace item, was made conscious to me since I had been in those many roles previously. In 1983, as a member of the third class of the first Ayurvedic Medicine program in the United States, I remember my teacher constantly remarking, "You Western students sure have very intelligent notebooks." While a product of the *misra*, or mixed Ayurvedic and biomedical program in India, he learned the volumes of the great works by heart. "It is all here on the tip of my tongue," he would often say. For him, the ability of an individual to internalize accumulated knowledge was the sine qua non for Ayurvedic competence.

Internalized knowledge acquisition, in the age of personal computers, PDAs, PowerPoint, CD's, zip disks, memory sticks and cards, and other, newer forms of data storage, is arguably less a pedagogical aim or personal motivation today than it was twenty years ago. The potential of the notebook has been surpassed, and transcended. The wonders of externalized acquisition, storage and accumulation created by post-Fordist technologies, have in my mind always formed a sort of dialectic against the model of my teacher; his built-in referents, theorems, hypotheses, and statements, intact.

Therefore, in conducting fieldwork, this "bias" just described concerning pedagogical and cognitive correctness in determining what or whom is an "authentic" Ayurvedic practitioner was one that I grappled with initially. Over time, I began to understand the power of culture and agency in taking what is useful in fashioning those syncretisms that occur in all societies. Meaning, as such, is contextually and socially relevant if not specific. My anthropological training proved most helpful in not succumbing to the temptation of essentializing human practices, confining them to putative groups or geographies.

As a former lecturer and practitioner of Ayurveda, I was aware of my own professional need to render Ayurvedic epistemology relevant and understandable to my students. Cross-translation of Sanskrit, Latin and English names of herbs used in Ayurveda in order to offer local, certified-organic herbs to clients, producing, and sourcing botanical formulations that would be palatable, and especially important, timesaving in terms of preparation, for busy Westerners, were calculated business

decisions. Many are the former acupuncture clients who discontinued treatment due to not having time to boil herbs for an hour every morning, and if they did, to be rewarded with a frightfully bitter brew to imbibe thereafter. It was apparent to me that the "spirit" of Ayurveda could only be released into this culture with a great deal of work and translation.

Bringing this personal history to this fieldwork project, therefore, brought with it a struggle with silence. Do I assume the traditional social scientist position as fence sitter, and observe quietly, even if miscommunication occurs? If Dr. Kaviraj[1] doesn't know the Latin, Chinese, or English name for a particular plant, mineral, or gemstone, should I chime in? Where should I draw the line between participation and observation?

For example, during a discussion on menopause, I, informed by Margaret Lock's (1993) work, asked whether or not hot flashes where a symptom of menopause in Nepal, as the phenomenon was non-existent in Japan. Dr. Kaviraj replied in the negative, that hot flashes did not figure in either popular wisdom or clinical experience in Nepal. Her answer produced an audible gasp from many of the female students in attendance, which, though students of Ayurveda, revealed their own cultural assumptions about the body in this case, based upon a learned Western epistemic construct universalized.

While it is quite simple to see the student response as a cultural assumption, the historically subjective and objective fact is that in their world, hot flashes are real. Robyn Kliger uses Kirmayer's (1984) definition of somatization as a "metaphor for social and emotional experience and nonverbal expression, and uses the body and its ills in place of verbal social communication" (1990:60). The pragmatics and exigencies of a local

knowledge, somatized historically, demand that even in the face of cross-cultural medical anthropological evidence, the social facts of the hot flash must still be addressed by Western practitioners of Ayurveda, US or South Asian-trained. This interaction led me to conclude that my participation in the workshop was useful, but required observation of my own impact within the group in conducting this fieldwork.

Ayurveda, Past and Present

The San Francisco Bay Area, a center of complementary and alternative healing in the United States, is home to at least three Ayurvedic educational institutions, and over fifty Ayurvedic practitioners, both from the US and South Asia. The Bay Area is also the home of the largest distributor of Ayurvedic medicines in the United States, as well as biomedical physicians and nurses acquainted with Ayurvedic methodologies, including several who practice Ayurveda. Cross-cultural diasporas of people, ideas, systems, and cultural practices in an ever more globalized world are reflected in the growth of complementary and alternative healing modalities such as Ayurveda, particularly in California. This study offers an opportunity to observe how these global movements crystallize and take form locally as new epistemes and praxes.

Ayurveda as presented in the United States is the product of historical factors that have shaped its scope, beliefs, and practices in South Asia, as well as in its newer, globalized form. Notions of Ayurvedic "authenticity" can be better examined through a historical lens in the attempt to understand Ayurvedic pedagogy and practice in the United States. However, medical syncretism between Ayurveda and other culture areas is not a recent phenomenon. A comparative history of the development of Tibetan

medicine will be outlined in Chapter Three, offering an example of Ayurvedic adaptation and incorporation into another culture area.

Zysk (1993) uses Dumezil's (1947) tripartite division of ancient Indo-European society as a template towards an understanding of the history and development of Vedic medicine. The first and second tiers or orders consisted of the priestly and royal, aristocratic classes respectively. Vedic medicine flourished around 900 BCE, according to Zysk, amongst the peoples of the third order- agrarian, rural, artisanal populations. This Vedic medicine, Zysk believes, is the historical precursor of later classical Ayurveda. Vedic medicine was originally concerned with the control and appeasement of malevolent spirit forces and natural forces as its predominant healing methodology (1993: XI-XIII).

At some point in time, this preclassical Ayurveda became equally focused upon empirically observing human and environmental interactions and their connection to health. Eventually, the two approaches were combined into what is known as classical Ayurveda around the Fifth Century BCE. Romila Thapar points out there was a movement away from the *bhishaja*, the shaman or healer, signified by the incorporation of formal medical study and the systematization of medical knowledge (2002:257-258) . Owing to influences further west, by the Fourth Century BCE, Ayurveda had become a system based on a humoral theory of air, bile, and phlegm (*tridosha*), which provided etiological, diagnostic, and therapeutic models for both physical and psychological disease processes (Thapar 1990:123). The shamanic origins of this new medical system remained, both as an independent system serving specific cultural needs, and as a part of

the formal educational system. Medical texts written in Sanskrit inscribed and reinforced this newly systematized knowledge: Technical treatises had social value; when written in Sanskrit, a group gained professional status (2002:258).

Tridosha as a homeostatic concept evidently predates similar Greek humoral concepts.[2] These concepts formed the basis of complex physiological constructs accompanied by a neglect of practical anatomical study. This led to an uncritical acceptance of past authority rivaling that of Galenic anatomy in Medieval Europe. Croizier asserts that while religious taboos contributed to the neglect of empirical anatomy, it was fostered by cultural and scholastic conservatism (1970:278).

Buddhism was the vehicle that carried the seeds of this medical epistemology in its travels across monastic Asia. Unfettered by Brahmin taboos and prejudices concerning dissection, meat-eating, and caste-pollution, Buddhism offered a free space for the nurturance and development of the Ayurvedic medical system. These wandering scholars- monks gathered, exchanged and disseminated information, much like the scholar-monks of medieval Europe.

Zysk points out the seminal influence of Buddhist promulgation of Ayurvedic Medicine. Brahministic notions of the impurity of medical practice and by extension, medical practitioners, created a vacuum occupied by Buddhist monks. The domination of the Ayurvedic medical faculty at Taxila by Buddhist monks is described by Zysk; the most famous, Jivaka, being the personal physician to the Buddha himself. Zysk suggests a Buddhist origin for canonical Ayurveda, Jivaka himself being contemporary with most speculated reference dates of the Charaka Samhita's emergence, around the 4th century

BCE. Zysk further charts the movement and progression of Ayurvedic medical epistemology and practice to Tibet, South and Southeast Asia, and China. Zysk demonstrates that Buddhist monks were responsible for this diffusion of ideas and practice. Romila Thapar writes that formal education was, "...in the hands of the brahmans and the monks of Buddhist and other monasteries" (2002:257). However, the mutually enhancing relationship between medicine and Buddhism enabled the spread of Buddhism throughout India and later Asia. Brahmin political skill found a means of later destroying Buddhism in India. However, scientific and cultural pragmatism compelled them to appropriate the Buddhist legacy of Ayurveda. Once in Brahmin hands, they proceeded to align Ayurvedic philosophy with orthodox Hindu philosophy and mythology in a manner that reinforced their political power. Royal patronage of medicine, and the cultural, social, and political authority it confers was too important for Brahmin India to lose to Buddhist monks who do not believe in the infallibility of the Vedas (Zysk: xi-xii).

Buddhist monastic and teaching of Ayurveda, exemplified by the universities in Taxila and Nalanda, preserved institutional Ayurveda until the Islamic invasion. Depending on whom one reads Ayurveda went into a period of decline during Muslim and British rule, only to be revived during the 19th and 20th centuries. Ayurveda-as-tradition was part of anticolonial and postcolonial imaginings of the independent Indian state. With the rise of right-wing Hindu nationalist groups in India, Ayurveda has been recruited as one symbol of autochthonous Hindu science (Bacchetta,

1999). Modern export Ayurveda is the contested product of this history. We will examine this further in Chapter Two.

The Research Setting

Fieldwork was conducted during a month-long course in clinical Ayurvedic practice for healthcare practitioners at a retreat center in Northern California. Situated on several hundred acres, providing a quiet, intimate space for learning and sharing, the Alta Mariana Center was the site of this Ayurvedic workshop. Classes were structured so that students had the option of attending daily for the entire month; weekends for the entire month, or; any weekend module during the month. I attended Fridays through Sundays the first three weeks, and Thursday through Sunday the final week

Vegetarian meals were served twice daily at 8:30 am and 5:00 pm. Dishes ranged from lasagna, to enchiladas, to that Ayurvedic staple mung beans and rice. Whole wheat bread, salads, fruits, tea, coffee, and milk were available during meal times.

Hiking trails encircled and crisscrossed the property, leading up naked hillsides that cascaded down into wooded glades. A summer of fieldwork, spartan vegetarian food, and hikes in the blistering August sun of Central California left this researcher twenty pounds lighter and in the best shape in years.

A well-stocked bookstore offered works focusing on Sanskrit, Yoga, Indology, Ayurveda, Hinduism, Buddhism, as well as New Age music and Vedic chanting on compact disk. An attached snack shop sold sandwiches and drinks catering to the between meal hunger and thirst of the Alta Mariana populace.

The Students

The workshop attendees were overwhelmingly female – twenty out of twenty-three. Of the three males, two were biomedical physicians. One was a longtime Bay Area practitioner of Ayurveda, and the other, a world-weary endocrinologist for whom Ayurveda represented an ideational escape from the legal, institutional, and professional constraints of American biomedicine. For him, Ayurveda was a philosophical realm where a physician could embrace the artistic and truly become a healer, a possibility inherent to biomedicine he believes, but made extremely difficult by its structure and strictures.

While this asymmetrical gender representation was somewhat surprising to me, such was not the case for many of the women themselves; it mirrored the composition not only of their previous Ayurvedic educational encounters, but their clienteles as well. The majority of the students were graduates or students of Ayurvedic schools in California. None of the attendees had a full-time Ayurvedic practice. In fact, many were perplexed as to the difficulty of getting a practice established. Most were however, employed in the healthcare sector. The list of attendees included, among others; one surgical nurse/ massage practitioner, one massage therapist, a pediatric nurse, two nurse-practitioners, one midwife, one chief nutritionist at a Bay Area hospital, and one medical secretary who runs her husband's medical office. There was also a second-year acupuncture student from Hawaii present. Another attendee is a graduate botany student at UC-Davis. The two nurse practitioners worked with the workshop leader, Dr. Kaviraj, in Nepal in the past, as participants in various health camps.

The Teacher

The teacher, Dr. Kaviraj, is a descendent in a family line of Nepalese Ayurvedic physicians. She was the first Ayurvedic M.D., OB/GYN in Nepal, trained and licensed in both Ayurveda and biomedicine. She also obtained an acupuncture degree in Sri Lanka. Her practice serves many poor, rural communities outside of Kathmandu. Situated at the crossroads of China, Tibet, Bengal and the rest of India, Dr. Kaviraj brings a unique Nepalese perspective to the teaching of Ayurveda. Fluent in Nepali, Tibetan, Chinese, Sinhalese, Hindi, English and Sanskrit, she is familiar, not only with Hinduism, but also with Buddhism. Nepal being the birthplace of Lord Buddha, she brings both religious syncretism and cross-cultural awareness to her teaching.

An American acupuncturist wrote about her and her practice after visiting her clinic in Nepal. This first exposure to the West through his book created avenues for her to travel to the West and teach Ayurveda.

Consumerism, Commodification, and Ayurveda

The Market

Alta Mariana Center as a research setting housed different parties within the Ayurvedic world each with different goals. Dr. Kaviraj was teaching in the United States, raising money to further her efforts back in Nepal. Most of the students were employed in the biomedical sector. For them, money, or the promise of it through Ayurveda, was not a surface concern. Altruism and Ayurveda might have had romantic overtones in some students, but it can be said that all parties, especially Alta Mariana Center itself, were quite well informed in terms of economic pragmatism. The dialectic

between altruism and economic pragmatism mirrors the changing parameters of Ayurveda writ large in contemporary pedagogy and praxis.

It might be helpful at this point to Hans Baer's (2003) critiques of Andrew Weil and Deepak Chopra. Taking an insightful look into the phenomenon of their success and raising questions about the implications for complementary health practices, and for our purposes, future complementary health education, Baer asks whether Weil and Chopra's market appeal to upper-middle and upper-class consumers carries an implicit valuation as to precisely what kind of people deserve to be healthy. The promise in the early years of the alternative and complementary health movement, that of being a dialectically-inclusive formation in contradistinction to a commodified biomedicine, has been effectively co-opted by the cross-over market success of Weil and Chopra. It is not lost on Baer that these two "New Age " gurus are biomedical physicians, and he concludes that they have not lived up to the promise and hope of alternative healing. By undergirding individualizing patterns, Baer says Weil and Chopra have actually created a capitalist-driven alternative medical hegemony that legitimizes social inequality.

According to Langford, (2002) Ayurvedic physicians in India consulted by Western tourists, think of Westerners as "doshic," or toxic laden, with the cultural baggage of consumerism and excess. Langford sees the irony of how colonized bodies, once thought only suitable for addressing the needs and desires of the colonized, are now eagerly sought out by fragmented excolonial and neocolonial bodies in search of wholeness and balance. It is the discipline inscribed into the bodies of the colonized, and the healing tradition that informs it, that Langford says is desired perhaps most of all by

the ex- and neocolonial, dissipated by desires driven by consumerism and excess in this late-capitalist age (2002:269). Langford's work is of relevance in that it provides a lens for observing how Ayurvedic medicine in California is practiced given the different cultural factors informing it than in South Asia. The deeper psychosocial needs and factors driving Western patient need as suggested by Langford and how they are addressed in Ayurvedic practice in California need to be examined.

Dr. Kaviraj said she was surprised at how everything in America is

> "...big money, big money. Even in Ayurveda here, big money. People spend great amounts of money, only not to follow through on your advice, because they are used to quick fixes and many choices. Meanwhile, in Nepal, we are a poor country: we could only wish for the resources that would allow us to build a sweat lodge that could fit 18-20 people. That would permit us to treat large numbers of people who could not afford the sort of herbal steam therapy people [with money] pay for individually."

Dr. Kaviraj is hoping to channel the money she earns in the West into developing a clinical and pharmacological infrastructure in the rural community she serves in Nepal. In Nepal, there are only two government Ayurveda hospitals. There is no government office of Ayurveda as in India, and the reality of a full government ministry of Ayurveda as present Sri Lanka, is only a dream.

When Dr. Kaviraj arrived at her first rural posting after obtaining her M.D., she was shocked to find the dispensary contained only two items, sulphur and boric acid. She processed them, obtained local herbs and built her practice from scratch, without capital. Therefore, it is understandable when she says, "It just tears my heart out," in reply to my rhetorical question, "Does 'big money' give the impression that only a certain type of person deserves to be healthy?"

She is troubled by what appears to be spiritual consumerism. Selling her craft in the American style poses ethical challenges for her. Yet, it is in the conflated realm of consumerism, medicine, and self-improvement, where most of the market action is taking place. Dr. Kaviraj wants to earn just enough to help her community in Nepal. She was fond of saying, "God has given us two great gifts – tears and the ability to forget." However, if she is going to be successful, she will find Western life-as-personal narrative psychology forms the basis of many of the most commercially successful healing modalities in American popular medicine, particularly in complementary and alternative (CAM) therapies and practices.

Late-capitalist consumerism as a symptom of Western malaise possibly informs one more strongly about the success of Deepak Chopra and Andrew Weil, as discussed by Hans Baer. However, consumption, whether of beliefs, objects, and practices, creates meaning in people's lives. Read this way, one's ability to consume is inextricably linked with class and access to particular lifestyles. Does middle class consumption create a path towards gaining political access and social acceptance? Does political access and class affiliation influence practitioner epistemology and clinical practice? We will approach these questions in later chapters.

Ayurveda in the US

Ayurvedic education in the US generally is available in three ways. First is through correspondence courses, usually advertising in yoga, new age, massage magazines, etc. The second is through short courses, sometimes offered through Ayurveda schools, yoga centers and ashrams, conference and retreat centers such as Alta

Marianna, or through individual practitioners. Lastly, Ayurveda schools provide semester, year, and multi-year programs for commuting students. Some schools hold classes on a monthly basis, others on a full weekday schedule.

The longest running Ayurveda program in the United States is the Ayurvedic Institute in Albuquerque, New Mexico. Open since 1984, it is run by Dr. Vasant Lad, former professor of Dr. Robert Svoboda, the first Westerner to complete study at an Ayurvedic college in India. For three years, before founding the Ayurvedic Institute, Dr. Lad directed the Ayurvedic program at the Institute of Traditional Medicine in Santa Fe. In Santa Fe, the program lasted two years; in Albuquerque, the program is for one year, with an optional second and third year for more advanced study in clinical and pharmacological Ayurveda.

Maharishi International University, or MIU, has offered Ayurvedic education at its Fairfield, Iowa campus for over 15 years. Their fortunes rose with the success of their *beau célèbre*, Dr. Deepak Chopra. The cult-like aura around the Transcendental Meditation movement has always engendered somewhat amused suspicion about their motives and ways of representing Ayurvedic epistemes and praxes. This suspicion is in no small way connected to the immense wealth of the organization. Even Chopra himself has severed all public ties with the organization.

All informants viewed Dr. Lad's program in Albuquerque as the best in the nation. However, work, relationships, and other local commitments made moving to New Mexico an impractical choice for most. Additionally, concerns around employment and financial solvency while in Albuquerque for one or two years were a factor. These

realities, combined with the growing demand for Ayurvedic education, created a vacuum filled by Dr. Solomon and others. One informant, a former member of Transcendental Meditation, attended Maharishi International University's Ayurvedic program, but dropped out, disillusioned, both by the quality of instruction, and the behavior of the groups' members.

The local Ayurveda college run by Dr. Solomon in California is representative of a new crop of Ayurvedic schools springing up around the country. His program consists of monthly, Friday-Sunday classes, for a period of 30 months. A "fulltime" program has also begun; although meeting three days per week for 15 months, total class time is only 9 hours per week. Classes in pharmacology and detoxification methods are not part of the regular curriculum and are available for extra tuition. How some informants responded to this set of circumstances will be discussed later.

Alta Mariana, in effect, is an island getaway from the mainland bacchanal of Ayurvedic education in the United States. By carefully choosing who teaches there, the center seemed a magnet for diverse groups of Ayurvedic students. Offering up to four different workshops simultaneously, Alta Mariana does not depend or rely on Ayurveda as a source of income.

The owner of the local Ayurveda school, Dr. Solomon, does not read Sanskrit, nor have any lineal relationship with any South Asian Ayurvedic school or teacher. His syllabus is based on the writings of an American writer, Dr. Raymond Hawley, not on any of the three classical Ayurvedic texts. His authority is derived from ownership and includes the right to fashion a school according to his wishes.

One of his former teachers, an Indian educated Ayurvedic physician with over thirty years' experience, has now set up her own school. As a former faculty member of the other school, she taught the first year students, using the course material written by the American Ayurveda author. Second and third year students were under the tutelage of the school's owner. An advertisement for her new school says, "Learn Ayurveda from Real Ayurvedic Doctors," an oblique reference to differences in faculty and teaching quality between her program and her former employer, the owner of the program studied in this project.

Chapter Two

Hegemony, Authenticity, and Ayurveda

In order to understand how Ayurveda has recontextualized into an American setting, it is necessary to understand the how Ayurveda was constructed within a specifically stratified South Asian context. Moreover, it is instructive to note that Ayurveda has been refashioned before, during, and after the colonial period. Those specific changes sometimes parallel those in the San Francisco Bay Area.

Medical plurality is the norm in both the United States and India. American and British biomedicine, are dominant in both the United States and India, respectively, but they are contested medical models. The political and social valence of Ayurveda has distinct local logics in each setting. In each setting, the state and the market define Ayurveda, consequently changing its definition through time. Certain markers, such as the use of Sanskrit, are salient in understanding how cultural capital is used to construct unique cultural and historical versions of Ayurveda.

A Hegemonic History of Ayurveda

Zimmermann (1999) outlines the ecological factors and political influences contributing to the normative process of establishing Ayurvedic medicine in India. He argues that political, linguistic, and ecological factors were inscribed into Ayurvedic texts hierarchally in ways that validated and propagandized a hegemonic discourse led by Vedic Brahmanism. This discourse posits that the land of the cow, North India is healthier than the land of the water buffalo, South India. North India was the home of the

Vedic civilization, Sanskrit based, as were the Ayurvedic texts, while South India lay outside the Vedic fold, and was originally entirely Tamil speaking and not originally vegetarian. The land of the water buffalo was derisively then named "The Jungle," a place not suitable for the establishment of healthy human life, and by extension, not conducive to the establishment of a "great" civilization such as the Vedic, situated in North India, of course. Zimmermann demonstrates that Vedic preoccupations with hierarchy accompanied their preoccupation with caste purity, yet Ayurvedic texts contradicted Brahmin vegetarianism itself. The "Aroma of Meats" refers to the paradox that Ayurvedic texts prescribe various types of meat, sometimes passionately describing their nutritive and therapeutic effects. This "aroma" contests Brahmin notions of caste superiority, culturally and therapeutically appropriate practices, and environmental determinism.

Underscoring this historical narrative concerning the development of formalized Ayurveda between the Sixth and First centuries BCE, is the environmental shift from the rural origins of the shaman to the new urban habitus of the medical doctor-cum-Sanskrit literary scholar. Moreover, the scholarly, literary, and academic refinement of those times caused Thapar to question if all of the authors were actually practitioners of the subjects about which they had written (Thapar: 2002:259). Buddhism and Hinduism were both participants in this new urbanity, and its literary *milieux*. The great Buddhist philosopher and alchemist Nagarjuna chose to write in Sanskrit for both challenging Brahminism and for engaging in Buddhist discourse - this despite the Pali origins of

Buddhism as a linguistic and literary rejection and contestation of a Vedic hegemony inscribed in Sanskrit (Thapar 2002:259).

Implicit to this historic shift from village to city, apprentice to 'formal' student, shaman to doctor/scholar, social medicine to professionalized medicine, is both an increased division of labor and sedentism. Sanskrit texts of the day mention, sometimes lamenting, this new urbanism. For example, medical texts associate humanity's movement away from nature to the cities as the cause of increased illness and disease; as well as the need to preserve healing knowledge based on nature in spite and for the sake of the increasingly dissociated masses.

The rise of mercantilism in India between 200 BCE and 300 CE stimulated and sustained this new urbanism, funding Hindu and Buddhist scholarship and their institutions. The professional guilds dominated economic, social, and scientific discourse, making it virtually impossible for an individual to compete against them. As their commercial fortunes rose in proportion with increased demand, guilds became engaged in both subcontract and slave labor. These guilds were caste exclusive, which assured its member associates of a reliable supply of labor (Thapar 1990:109-110).

Furthermore, architectural guilds designed, and artisanal and craft guilds erected, the great Hindu and Buddhist temples and stupas of the period, as well of course, the new urban centers themselves. Financed by political elites, these projects were advertisements of both guild and state power. Guild inscriptions on temples and stupas reveal that a guild could be banker, financier, and trustee of its and other guilds projects. Using foreign currency such as Roman *denarii*, guild affairs in India during this

period reflect the international monetary, and by extension, cultural and intellectual exchanges occurring. Caste attitudes prevented foreigners from rising in the sociopolitical hierarchy. By ensuring the wellbeing of these guilds, the state sought to dampen guild political ambition and potential, given their considerable economic power (1990:110-112).

Sanskrit was the language of the academy, the professions, and religions. Never a living language, it was the lingua franca of the Brahmin caste and increasingly, the language used by the Buddhist monk. Ayurvedic medicine of that time was a construct of these international political, economic, and social facts and influences, contesting modern politicized notions of Ayurveda as an autocthonous, self-originating Hindu medical system. As Buddhism faded from India, these texts became part of a larger meta-narrative written in Sanskrit, which sought to weave foreign, indigenous, and political histories and practices into a sacralized mythology chronicling Hindu Brahmin determinism and exceptionalism. This occurred, in part, as a contestation and in many respects, appropriation, of Buddhist, Jaina, and other heterodox practices, which include Yoga and Ayurveda.

Basham avers, stating,

> "Thus Hinduism revitalized itself and was able to slowly supplant the heterodox religions. The brahmans (sic), who regarded themselves as the interpreters of Hinduism, were able to rewrite the older texts to conform to their own vision of society, as is evident from Puranic literature, and were able to convert popular secular material, such as the two epics, the Mahabharata and the Ramayana, into sacred literature" (1975:48).

Through Sanskrit, religious institutions, the guilds, their respective academies, and those political forces that sought to control them through patronage, inscribed a vision of

society that reinforced hierarchal structures and notions concerning the obligations of those bodies. The contemporary relevance of Sanskrit to Ayurvedic education in the West as related by my informants will be taken up later.

Ayurvedic texts exhibit a highly developed social division of labor, from the ceramic and stoneware used to grind medicines, to the technology used to grow and process oilseeds, sugarcane, grains, and pulses. How the Ayurvedic practitioners at the workshop describe their experiences as individual practitioners as regards their relationship to time and labor in a post-Fordist present will be related in Chapter Three.

In describing the pervasive cultural and social power of Ayurveda in Indian society, Sudhir Kakar writes:

> "In contrast to Western medicine, however, Ayurveda has been less a mirror of the cultural belief system than one it its chief architects. Its contribution to the shaping of Indian consciousness derives from its overwhelming monopoly of the theory and practice of healing for scores of centuries till it was recently challenged by Western medicine" (1982: 221).

Ayurvedic medicine has been the historically dominant medical system in India over the last two millennia. However, religious and political forces have shaped the character and representation of Ayurvedic medical knowledge in quite different ways. Ayurvedic history, therefore, informs the analysis of modern Ayurvedic representations.

Ayurvedic Authenticity

Any examination of Ayurveda or any medical system must necessarily begin with the premise that it is a cultural product shaped by historical, political, religious, and societal influences unique to its various local manifestations. Is this prepackaged, commodified, imported Ayurveda any more "authentic" or "correct" than the Ayurveda

taught in India, or more to our purposes, that being taught in the West, increasingly by those who have never studied in South Asia?

The answer perhaps becomes more easily understood when the gaze is broadened to understand the wider medical plurality of India. Homeopathy in India was an introduction by the British, where it quickly became incorporated into Indian medical and intellectual culture. Incorporation of the materia-medica of both Ayurvedic and Islamic (Unani Tibb) medical systems into the homeopathic repertoire occurred quickly. The resulting homeopathic medical system was recognizable conceptually as the child of Samuel Hahnemann, but its epistemological orientations and clinical praxes bespoke its South Asian medical sensibilities. Indian homeopathy, regulated by the government of India, suggests a history in which an inward, sociocultural gaze became necessary for the development of a culturally relevant and viable and system of healing. In particular, it had to address the needs of the hundreds of millions of suffering Indians unversed in either the world of Samuel Hahnemann or that of the English language.

Ayurveda in California, as suggested by this work, may also have to adjust to the realities of western cultures and the somatization processes unique to them, particularly the psychosocial constructs that influence such processes. For example, Cartesian duality as a psychosocial construct is an historical fact operating within the psyches of almost all educated in the Euro-American intellectual tradition. Erwin Straus writes, "The wound cut by the Cartesian dualism of mind and body is covered over, but no yet healed, by mere reference to the mind–body unity… The idea of a mind–body unit demands, first of

all, a revision of the traditional concepts of psychology which are shaped in accordance with a theory of a mind–body dichotomy" (1966:164).

Ayurvedic practice in the West of necessity must adjust to the epistemic constructs and notions Western students, clients, and consumers bring to the classroom, clinic, and marketplace, irrespective of textual prescriptions and proscriptions. Texts may fuel belief much more easily than practice. This is instructive for this examination of Ayurvedic pedagogy and practice. Despite right-wing Hindu rhetoric blaming Buddhist, Muslim, and British power in causing the reversal of Ayurveda's growth and evolution, Leslie suggests this was not the case:

> "...this was mythology. Ayurvedic practices in the eighteenth and nineteenth centuries were different from those described by the classic texts, but this did not mean that Ayurveda was a ruin and vestige of its past. Physicians probably did not practice medicine the time the texts were written in exactly the way they prescribe. *They are normative works, and what books say that people should do is always problematic in relation to their actual behavior* (1992:195, emphasis added).

The Orientalist-inspired rhetoric utilized by the Hindu right-wing was part of the discourse that shaped the development of modern Ayurvedic epistemology and pedagogy. This modern Ayurveda is the accretion of this discourse, which is the model exported for current consumption in the West. A discussion of Ayurvedic scholarly historical continuity will occur later in this work, but what follows is a look at the political factors moulding the contours of modern Ayurveda.

Nationalism and the Colonial Body

To better understand the historical contexts in which modern Ayurveda developed, it is helpful to examine the political and hegemonic forces that shaped

it. "Modern" Indian history is not yet sixty years old. Intensely studied since 1947, it has gone through several phases. In the early post-Independence period, modern Indian historiography was contested between imperialist history and nationalist history, the latter employing Marxist analyses in their efforts. Imperialist histories represented British rule as being beneficial to India by politically unifying the subcontinent, establishing the rule of law, modern industries, educational institutions, etc. By the 1960s, a newly matriculated group of Indian historians began to challenge imperialist interpretations of Indian history. It was their view that colonialism had negative effects economically and culturally in India. Modernity and political unity were, to this new cadre of Indian scholars, the rewards of struggle, not a gift from Great Britain (2000:12).[3]

Since its origins around the beginning of the twentieth century, Hindu nationalism was until the late 1930s, composed almost entirely of upper-caste males. Using Benedict Anderson's (1983) terminology, Paola Bacchetta (1999) called the Hindu nationalists' ideology an "imagined community" because it was based on an imagined India devoid of Muslims, Jains, Parsis, Sikhs, Jews, Christians, Buddhists, animists, atheists, and all other non-Hindus.[4] It ran counter to the goals of secular Indian nationalists like Nehru. It should be kept in mind that Hindus make up around 80 percent of India's population. Of that, Brahmins constitute only about 4 percent, and they have been active historically not only in Hindu nationalist, but communist, socialist, and secular nationalistic movements as well (1999:5).

Emergent Indian nationalism existed, therefore, within a larger colonial context, in which the body, medicine, and national identity were contested in the larger realm of

hegemony and political power. Edward Said (1979) elaborates on the colonial deconstruction of the Oriental body in the nineteenth century. European discourses of the time, backed by "modern science," saw the Asian Other, not as *Homo sapiens*, but as *Homo orientalis*, a polygenetic construct first, a human being, perhaps second:

> Thus within broad, semipopular designations such as "Oriental," there were some more scientifically valid distinctions being made; most of these were based more principally on language types – e.g., Semitic, Dravidic, Hamitic – but they were quickly able to acquire anthropological, psychological, biological, and cultural evidence in their support (1979: 231).

These conflated, racialized constructions of otherness based on linguistic difference have produced some awkward posturing in the postcolonial Indian national imagination. In India, many Tamils refuse to acknowledge Hindi or Sanskrit. In Sri Lanka, "Aryan" Sinhalese versus "Dravidian" Tamil divisions were later appropriated for nationalistic political purposes, using Ayurvedic medicine as an index of indigeneity.[5]

The Policing of Colonized Knowledge

Despite the political and cultural posturing, the entire postcolonial period in India has been marked by the protection of elite biomedical interests. Science in the colonial period, to which Said referred, became the gauge of truth concerning colonized knowledge in post-Independence India.

The Drug and Magic Remedies Act of 1954 prevented indigenous practitioners from advertising their remedies for, among other things, sexual incapacity and menstrual disorders.[6] Coincidentally perhaps, two of the eight subspecialties of Ayurveda are obstetrics and gynecology, as well as virilific and fertility therapies, which are libido and reproductive enhancement treatment modalities. By prohibiting advertising of

indigenous medicines for use in menstrual disorders, an entire class of midwives were legally barred from publicly spreading word of their services in written form. The Drug and Magic Remedies Act of 1954 was a pro-biomedicine piece of legislation, as it in effect concentrated medical privilege in the hands of an elite male few. Five thousand years of recorded history on the Indian subcontinent and a population of nearly a half billion people were unconvincing concerning indigenous Indian cultural knowledge about fertility and reproduction. Indigeneity as nationalist tool becomes suspect in the face of elite interests.

The Udupa Report of 1959 advocated the combining of Ayurveda and biomedicine. It stated, "The new syllabus chalked out by the "Shuddha" (Pure) Ayurveda people is only a rehash of the old integrated system of medicine and even the pure Ayurvedic institutions have included in their syllabi modern science subjects." An important statement, as it sought to address heated student strikes demanding the inclusion of Western biomedical courses into the "Pure" Ayurvedic curriculum.[7] [8]

What was at stake during the twenty-five year period from 1958-81 was a contestation of cultural and social authority in the arena of medical politics. This period saw the number of registered Ayurvedic and other practitioners of Indian medicine fail to keep pace with population growth: in some provinces, there has been a near disappearance of indigenous practitioners. The five-year period between 1985-90 saw funding for Indian indigenous medical systems, as a percentage of total Ministry of Health outlays, almost 70% less than the period 1969-74.[9]

The Indian Medicine Central Council Act of 1970 consolidated Ayurvedic educational authority in the hands of the state. This it achieved by regulating and mandating a prescribed mixed Ayurvedic curriculum combining classical Ayurveda and biomedical courses. Over the next thirty years, consequently, the type of student admitted to most Ayurvedic medical programs would tend to have a science background rather than a Sanskrit one (Langford 2002:115-116).

Hindu Nationalism, Women, and Postmodern Ayurveda

Contemporary Hindu nationalist women have begun to contest Hindu male dominance through a judicious blending of religious symbolism, late twentieth century cosmopolitan discourses, and Ayurvedic medical practices. Goddesses such as Ashta Bhuja and Bharatmata, all modern creations of the right-wing, Hindu nationalist party, the Rashtriya Sevak Samiti, or RSS, have been embraced by their female members as objects of worship. To a lesser extent, Indira Gandhi has been elevated to this pantheon, despite her secular credentials. Female members of the RSS, or Sevikas, are however, challenging and opposing institutionalized Hindu practices such as dowry, widow burning, bans against widow remarriage, and one of the most modern, amniocentesis for the purposes of determining gender (Bacchetta 1999:4-7). Ayurvedic medicine, if properly followed, holds forth an eternal promise to Hindu women grappling with such postmodern practices as amniocentesis and clinical abortion. This promise, it appears in some quarters, is only extended to Hindus, as we shall see.

When a RSS Sevika named Ratna's youngest daughter-in-law became pregnant, after having previously given birth to a girl, she said:

> "She went to an Ayurved doctor. He told me (that) to get a son, you have her drink hot milk with melted gold. I gave her the milk every day. And she got a son. These are ancient methods. They are part of our culture." (1999:7)

This position does not oppose abortion of Hindu female fetuses and all Muslim fetuses, but only of Hindu male fetuses. Her sentiment, in a sense, implies a Hindu nationalism as a paternal nationalism, birthed by an imagined Hindu female body inscribed upon and sacralized by a postcolonial Ayurvedic scientific eugenics. It is an anti-female, anti-Muslim eugenics, whose uniqueness lay in its medical applications utilizing non-Western medical and religious knowledge systems in postmodern nation-state politics. In this respect, Ayurvedic medicine gives Hindu national mythmakers a resonant language of pseudo-validity possessing inestimable political utility.[10]

India has a Department of Ayurveda, Yoga & Naturopathy, Unani, Siddha, and Homeopathy (AYUSH). AYUSH exists as a department within the Ministry of Health and Family. *Ayush* in Sanskrit means "life," and as such, the acronym, within Indian medical, religious, and secular contexts, articulates a Hindu scientific nationalism of the present validated by questionably attributed primordial antecedents associated with Ayurveda, Hinduism, and the Sanskrit language.

However, from the 1950s until 1990, there was a fundamental dishonesty at work. It contained all the elements of postcolonial mimesis of the colonial or the modern, combined with the exigencies of class politics. Using notions of a "pure" Ayurvedic medicine as a cover, national elites failed to follow their words with actions in truly promoting indigenous medicine.

Representations and Contradictions

As mentioned earlier, changes were occurring concerning postcolonial representations of Ayurveda in India. The same was occurring in Sri Lanka, with an Indian interlocutor, Pandit Shiv Sharma, providing much of the excitement. Sri Lankan Buddhist and Indian Hindu religious, medical, and political epistemologies are both contextualized by the same historically imagined racial identities. Upper-caste Hindu Brahmins and Buddhist upper-caste Sinhalese mutually claim "Aryan" Vedic civilizational origins in North India. Tamils, Muslims, and later the British, became "foreign" influences, from which Sinhalese and Hindu nationalist Ayurveda had to be defended.

Shiv Sharma was the upper-caste Brahmin elite cousin of the Sinhala upper-castes of Sri Lanka. Sharma himself ordered laboratory tests and x-rays for his patients, and his only son became a biomedical doctor. He was of the belief that Unani medicine was a dying Islamic shoot grafted onto the living tree of Ayurveda on Indian soil. A Brahmin pandit, vegetarian, and golfer, he personified a rare and desirable conciliation of traditional and modern identities to many upper- and middle-class Indians. However, in 1959, Sharma appealed to Sri Lankan bureaucrats to keep Ayurveda and biomedicine separate.

Leslie writes:

> "His advocacy of pure Ayurveda flattered an Aryan sense of continuity and self-sufficiency while accommodating policymakers *who also wanted the whole imported package of professional medicine from Europe and America.*" (Leslie 1992:182-184, emphasis added)

Colonial mimicry by postcolonial elites has roots in the colonial experience itself. For

the purposes of this project, what is clear is that the processes of building the national medical imagination were similar in both Sri Lanka and India. Dialectical relationships between Ayurvedic and Western biomedical hegemonic discourses, represented by colonial medicine and indigenous practice respectively, took on new forms of political ideation. Ayurveda as symbol of Hindu primacy and national continuity is but one such form.

Therefore, evocations of essentialized cultural and religious sentiments in the name of the nationalist project, by the very postcolonial political elites who created them, obfuscated other, more pragmatic objectives. By controlling access to sources of global education, knowledge and experience, upper-caste Hindus were able to retain power in Indian society. The postcolonial reconstruction of Ayurveda embodied and articulated the reality that is the postcolonial mind.

Postcolonial thinking was perhaps most acute among South Asian elites because it was an historical construction, a colonial project, into which previous generations had been co-opted.

Michael Adas writes:

> "Through state-supported and missionary education, Western colonizers sought to propagate epistemologies, values, and modes of behavior that had originally served to justify their dominance and continued to be valorized in the rhetoric of governance. The elite-to-elite emphasis of the transmission of the civilizing mission ideology meant that it was hegemonic in a rather different sense than that envisioned by Gramsci's original formulation of the concept.[11] To begin with, it was inculcated across cultures by colonizer elites onto the bourgeois and petty bourgeois classes that Western education and collaboration had brought into being. Only the Western-educated classes among the colonized were exposed to the history of Europe's unprecedented political, economic, and social transformations, and only these groups were expected by their

> colonial overlords to emulate them by internalizing the tenets of the civilizing mission ideology."(Adas 2004:37)

The liminality of modern and postmodern middle-class cultural identity exists, therefore, as a kind of fulcrum balancing urban elite postcolonial mimicry on one hand, and on the other, the marginal majority, the rural masses, whose life-worlds still revolve around the semiotics of traditional religion, communal and caste politics, and traditional medicine. Excellent examples of this middle-class identity at work against the interests, practices, and cultural knowledge of the masses, were the Drugs and Remedies Act of 1954 and the Indian Medicine Central Council Act of 1970. The Indian Medicine Central Council Act of 1970 took Ayurvedic teaching out of the hands of family and practitioner lineages and into the hands of the state. The state, through the Drugs and Magic Remedies Act of 1954, sought to control Ayurvedic practice in a manner that reinforced Western medical hegemony in India.

According to Leslie:

> "With few exceptions, political leaders felt that doctors should determine health policies and the interest of the organized profession was to keep as much control as it could over new technology and the market for medical services. The 'pure' curriculum curtailed training in diagnostic and therapeutic techniques for students in the indigenous medical colleges. Middle-class people who were sensitive to foreign conceptions of India, and whose children might become doctors, did not want their government to get out of step with the world system by integrating Ayurveda with cosmopolitan medicine" (1992:194-195).

Ayurveda and other essentialized discourses of "tradition" are no longer able to divert attention away from elite patterns of globalized access and consumption. India's position today as the world's largest democracy and, with China, the largest producer of science graduates, suggests an irreversible movement towards the acquisition and production of

globalized knowledge. From the late 1970s to the present, those brilliant minds who, in a previous era would have entertained an Ayurvedic or Shastric career have increasingly sought their futures in globalized technologies and knowledge systems. The Brahmin engineer is no longer an oxymoron, nor an exception. In many places today, it is almost a mutually inclusive term.

How secular governmental power in India responds to the democratic aspirations of its rural masses clamoring for more things global, as the elites and upper-castes have long since done, is unknown. The rural masses, left out of the postmodern opportunities of Western education, upward mobility, and modern, much less postmodern, conveniences, are demanding their due. They want the same opportunities for that identity reconfiguration the Brahmin engineer has effected in his or her own life. What is clear, however, is that, to paraphrase Chakrabarty, "They want modernity and national unity, not as a gift from the Brahmins or the British, but as a reward for their struggles."

Paralleling the move away from traditionalist/communalist epistemic politics and knowledge bases is the current state of Ayurvedic practices in India. There are four types of practitioners today. Professional doctors or *vaidyas*, are today usually graduates of Ayurvedic colleges or descendants of family lineages of vaidyas. Itinerant peddlers, predominantly aboriginal tribals, collect plants in the forests, jungles, and hills, which they sell in villages and market towns. The third group of healers, temple priests, especially of the Vaikhanasa order, are required to perform the duties of a physician. Lastly is indigenous folk healing, broadly including tribal medicine, shamanistic practices, and home remedies. All four forms are in a state of decline in

India, in terms of both numbers of practitioners, size of the total knowledge base, and quality of knowledge transmission, whether through teaching, writing, research, or apprenticeship (Rao 1985:2).

The Pragmatics of Modern Ayurvedic Education in India

As written earlier, today's Ayurvedic student in India has more of a background in science than Sanskrit. Debate on whether Shuddha (Pure Ayurveda) or Misra (Mixed Ayurveda and Biomedicine) in the 1960s and 1970s was rendered moot by increasingly globalized knowledges and technologies. Governmental organizations and international organizations of the time were putting energy and money into developing primary health care programs based on the cosmopolitan public health models and systems of the West. Ayurveda and other forms of indigenous medicine were lauded in speeches, but their institutions were ignored in this new public health care system. The new discursive power of biomedicine, however, soon had Shuddha practitioners using the language of biomedicine, and committing themselves to the scientific research of Ayurvedic medicine. Consequently, Ayurvedic education was about to change.

The realities of modern day Ayurveda in India is that the practitioner would not able to maintain a practice without using stethoscopes, blood pressure cuffs, or giving vitamin injections. I was informed while in India that many Ayurvedic doctors also prescribe and dispense aspirin, acetaminophen, and antibiotics, causing much consternation amongst local biomedical practitioners. The consternation was not due to any concern of medical negligence occurring, but rather, according to the biomedical practitioners, it drained patients away from them. The reason given was that most people

trusted Ayurvedic doctors, more than biomedical doctors: they have more cultural capital, so to speak. What cannot be denied is that what is in demand is biomedical services and drugs. Ayurvedists have had to come to terms with this fact in order to survive. Therefore, it can be seen how the rise of interest in Ayurveda in the West by people already inculcated in the culture of science would provoke interest in some vaidyas concerning the possibilities of teaching there or teaching Westerners in India.

Dr. Kaviraj's degree is a *misra* or mixed degree – Ayurvedic medicine and biomedical obstetrics and gynecology, from Benares Hindu University. She is pragmatic enough to know when biomedical procedures are essential, but she wishes that Ayurveda was given more of a chance in the clinical setting to prove its efficacy. In her opinion, at times unnecessary procedures are performed and potentially harmful drugs prescribed in conditions more conducive to Yogic or Ayurvedic treatment. She feels that in this and other regards, Ayurvedists have been more open to biomedical concepts and collaboration with biomedical physicians, but not so the other way around.

Chapter Three

Epistemic Interactions – Personal, Cultural, Medical

Cultural Epistemes

Sudhir Kakar's (1999) notion of Euro-American subjectivity is one of autobiography and personal narrative in contradistinction with Indian subjectivity, which according to Kakar is "guarded against narcissism." This theoretical lens provides a means of examining Euro-American students' approach towards not only Ayurveda but also the social construction of health, healing, the body, and illness.

To understand the cultural factors Euro-American students bring to Ayurveda, and the cultural factors Ayurveda brings to the West, Sudhir Kakar's observations might prove useful:

> "In my encounters with Indian healers and healing traditions, I was often aware of a general feeling of ambivalence. One side of this ambivalence ultimately derives from my being a Western-trained psychoanalyst in a culture whose soil is not particularly conducive to psychoanalysis, either as a method of therapy or as a theory of human nature. For instance...it is rarely recognized how much of a certain kind of introspection – a sine qua non for psychoanalysis – is a peculiarly Western trait, deeply rooted in Western culture...(by contrast). Even today, in the essentially-Western-inspired genre of autobiography, Indian writings tend to have a curiously flat quality as far as scrutiny of life in terms of a ruthless examination of motives and feelings is concerned" (1982:7).

Kakar says this is an observation, not a criticism, pointing to the absence of an Indian equivalent of Euro-American style introspection, at least outside of the Westernized Indian middle classes and the metropolitans of Calcutta and Mumbai. He is of the opinion that introspection in the Western sense would require an education, a re-

orientation of the Indian masses, if Freudian psychoanalysis were to become relevant to and possible in India.

He goes so far as to say that the "self" both cultures seek to know are different entities as well. The self of Socrates is not the self of yoga or Ayurveda. The self of yoga and Ayurveda is beyond time and space, without the subjective dimension of life history and personal narrative characteristic of Western epistemes. According to Kakar, life history forms the basis of psychoanalysis and Euro-American romantic and autobiographical literature (1982:7-8). If anything was more apparent during this period of fieldwork, it was this interface, or dialectic, between the self of Socrates and the self of yoga and Ayurveda, within the shared learning and clinical space of the workshop.

Langford (2002) presents a wide-ranging view of the practice of modern day Ayurveda in India and the West, and the epistemologies that inform it. Differences in psychological, familial, and cultural orientation resulting in different clinical encounters are examined. For example, Langford notes that most all Indian patients she saw who presented to clinic came with family members, who also were part and parcel of the medical consultation, the healing encounter and process considered indispensably social in context. The Euro-American clinical context, however, contrasts from the Indian milieu in that patients usually came alone, had little family support, or sense of health being necessarily a socially-dependent construct. To emphasize this point, Langford opines that Ayurvedic clients in the West actually tend to use knowledge of their *prakriti*, or constitutional type, as a means of individuating their personalities within a cultural context that reinforces and affirms such behavior.

Kleinman (1980) was convinced from his experiences that Western cultural assumptions burdened biomedical epistemology with a theoretical and value orientation giving it no tools for assessing patient and lay views on any sickness experience. Kleinman goes on to write that that this cultural bias left biomedicine with no means to explain alternative therapeutic realities possessed by other healing systems.

Such cross-cultural discourse and its cognitive possibilities, challenges many, academics and scholars alike. Cohen remarks that most European and American scholars of Traditional Asian Medicine (TAM) he has spoken with *do not believe that the system they study actually works.* This, Cohen says, raises questions about intellectual versus embodied practice. Other scholars promote and support various TAM practices, or use them as "narrative protagonist" in contesting biomedical, scientific, and state monologues (1995:324-325).

This dissonance, arguably, is the product of ingrained cultural epistemes, which for purposes of studying Ayurveda is the West, raises questions about how its students approach, cognate, incorporate, and practice its epistemes and ontology. A dialectical relationship between belief and practice emerges. Can there be practice without belief? Can there be belief without practice?

Posing questions to medical historians, medical anthropologists, doctors, students concerning the relationship between intellectual vs. embodied practice and agency, Cohen asks,

> "To which doctors (do you) subject one's body, and for what? – often presents a contradiction…I am not interested in accusations of bad faith. The problem is not that one cannot say interesting things about Ayurveda unless one is a patient. It is, rather, that *of the relationship*

> *between one's embodied and one's theoretical practice.* Does a lack of bodily engagement influence the forms through which practice is embodied? Thus my question: Whence the seduction? Do forms, through which we embody our interest – medicine as bounded and ultimately, hermetic, systems or more recently, epistemologies – offer us clues?" (1995:325, *author's emphasis*)

But the growing popularity of new forms of bodily practice such as hatha yoga are beginning to challenge Euro-American notions of what constitutes a healthy body. The majority of workshop attendees practiced yoga and some were teachers. They firmly believed (and were taught in the local Ayurveda school) that yoga and Ayurveda were "sister sciences" (which is not historically correct). More importantly, the increasing popularity of hatha yoga suggests that shifts in Western ideas of what constitutes a healthy body are occurring.

Kuriyama (1999) describes the epistemological and ontological differences between ancient Greek and Chinese medical systems concerning the body. He illustrates how visual perceptions about what constitutes the ideal, healthy, body are portrayed in both cultures. The Greek ideal, the sculpted Atlas and Hercules, with strapping, well-defined musculature is contrasted with the pot-bellied Taoist monk drawn with no visibly observable musculature at all. Kuriyama posits the Greek, and by extension Euro-American, concept of the body as one of the will exerted through musculature in order to effect change in the world physically, while the Chinese concept of the body is one of energy, not of mass, harmonizing with the energy of earth and heaven in order to create health. This implies an absence of ego, will power, notions of individualism, and exceptionalism, all highly valued qualities in Greek and Western notions of what should impel, compel, and propel the body most virtuously. The significance of Kuriyama's

work is its associating these different bodily epistemologies and ontologies with globalized movements of ideas, practices, and healing systems as affecting changes in American patient epistemology and ontology, as well as informing complementary and integrative medical practice. Tai Ch'i, Hatha Yoga, Ayurveda, Chi Kung, Tui Na, Shiatsu, etc. by their accumulative presence and activity in California, as well as through immigration of people from their place of origin, has helped shape popular discourse, social knowledge, and individual agency concerning complementary medical practices by informing patient epistemology and ontology.

Berger and Luckmann (1967) go one step further by stating that reality itself is a social construction. Reality as a social construct relegates illness, health and healing to a small subset of larger, if not more numerous constructs of lesser or greater tangibility that influence discourse and shape policy. It stands to follow that in this new gumbo of varied epistemes and practices, the inscribed body of any one medical system can no longer be considered an objectively atemporal, ahistorical construct. "For the lived and mindful body is not the stable universal which both cultural and practical accounts tend to assume in offering it a rather passive presence in grand theory. It resists its reduction to any one totalizing frame." (Cohen 1995:321)

Medical Epistemes

The pulse diagnosis weekend intensive, during which Dr. Kaviraj taught the basics of pulse diagnosis, exposed cognitive challenges for many, if not all, of the attendees. Pulse diagnosis is not a modality one learns in one weekend, but for the majority of the attendees, it was not their first or even second attempt at learning it. I

later learned that some had already studied, been given credit, completed clinical internships, and graduated from a local Ayurveda school without learning Ayurvedic pulse diagnosis. Much to my surprise, none of the four students from this local Ayurveda school was able to effectively learn, much less detect, pulse diagnostic parameters and data as outlined by Dr. Kaviraj. The ability to turn the mind off, and transform it into a reflective mirror passively receptive to the client's pulse impressions seemed very difficult to effect. One student later said it was "very difficult for a mind trained to actively pursue, investigate, analyze, and find answers and solutions, to quiet itself down." However, in the attempt to grasp the "secret" of pulse diagnosis, and failing, mystification of both the attempt and the grasping effectively takes place. Pulse diagnosis, one of the most intimate interactions in the Ayurvedic practitioner-patient relationship, becomes one of the most estranged.

Rhonda illustrates this dilemma. The class was joined the following week by Rhonda, a graduate of the local Ayurveda school. Now on staff there, she admitted that she still cannot take pulse, does not know what she is doing, feeling, or experiencing when she performs it, and with rousing laughter, quite honestly has "given up hope of ever learning it properly."

Cultural dissonance cannot be at work here: Chinese medical programs in the West produce hundreds of qualified practitioners each year, who would not have graduated without proving their pulse diagnostic skills – the one student who was able to make sense of the pulse workshop happened to be a student at a Chinese medical college in Hawaii. In her program, she said,

> "We each take turns reading the pulse after it has been read by the professor. The professor indicates what phenomena to look for, and we don't move a step forward until we all have experienced and confirmed it. It's a class we know we have to pass, so we just get on with it."

The Ayurveda students I encountered said they became students of the system as a vehicle primarily for personal growth and healing. Professional aspirations and their attendant economic prospects were not major factors in their educational choice. It was a new chapter in their personal life histories. Acupuncture students, on the other hand, enter programs with professional aspirations and possibilities intact – the cost and duration of their training, and legal status of acupuncture, invites a different type of student, with a different, perhaps more pragmatic, type of attitude. However, no ethnography or study examining student competence in learning Chinese pulse diagnosis in the United States has been undertaken. Research is needed to study this outstanding question of cognitive acquisition.

The Ayurvedic students' frustration in learning pulse diagnosis, however, was not due to any intellectual or professional shortcomings (several students are registered nurses), or cognitive dissonance in relationship to South Asian teaching styles. It was evident from the weekend's teaching that Dr. Kaviraj could train them all successfully, if she had the time and opportunity to do so. To do so, however, she would have to create the space and the conditions conducive to the teaching and learning of pulse diagnosis.

How does a cohort form within a Tower of Babel of personal narratives? How is group unity and cohesion fostered? How can a liminal space be created, in which all can learn? The answer, van Gennep and Turner would suggest, is the collective ordeal, or rite of passage.

As Kakar notes:

> "Ambivalence and marginality have, of course, their uses; the boundary spaces between cultures are not necessarily bad places to live in, especially if one can call on a few kindred souls for company" (1982:9).

In the case of the pulse diagnosis students, informational, professional, and institutional inequalities are legitimized as success or failure in learning pulse diagnosis is relegated to the realm of the individual. What validates it are the individualized values and patterns internalized by culture and sacralized by new age epistemology.

In *Being Human: the Problem of Agency* (2000), Margaret Archer suggests that this cognitive 'translation' is both constrained and enabled by the relations between three knowledge forms – practical, embodied, and discursive knowledge. Embodied and practical knowledges are both concerned with pragmatics, utility, and instrumentality. Discursive knowledge contests and expands embodied and practical knowledge, thereby implicating and explicating existing theories of causation and other epistemic assumptions. Archer challenges Bourdieu's (1990) denial of any intercommunication between practical and discursive knowledge. Archer asserts that their differences and subsequent incomprehensibility are due not to differing "logics," or ways of knowing as Bourdieu posits, but to differing ontologies, or forms of beingness, which require and makes operational their intercommunicative processes (2000:178-179). Supporting Archer's thesis, the majority of informants said they were attracted to Ayurvedic concepts precisely due to their perceived "natural," and "simple," epistemes, which for Carole, felt "intuitively right." Through engagement with Ayurvedic discourses and epistemes over time, their practical and embodied knowledge bases have expanded.

Associating embodied knowledge with the natural order, practical knowledge with the practical order, and discursive knowledge with the social order, Archer's model offers useful insights into the study of cultural and cross-cultural cognition, adaptation, in short, all creativity responsible for generating new forms of cultural and material production. According to this model, embodied knowledge is *demonstrated* as practical knowledge, while discursive knowledge challenges, contests, and changes existing practical knowledge through its *application*. This novel practical knowledge, when *incorporated* by individuals, creates new ontological domains. This embodied knowledge then becomes part of the individual and societal *natural order*, reinforced through its repetitive demonstration as a practical knowledge. Practical knowledge serves as a metaphor, utilizing existing tropes and notions, for the purposes of initiating new discourse, generating new discursive knowledge. Individuals and societies negotiate between these three knowledges. Agency and constraint, the products of embodied and discursive knowledges respectively, in turn determine what is possible, and what is practical. What is central here is the primacy of "practice" over "meaning", "doing"over "thinking", in contradistinction with Wittgensteinian theory, which places epistemology before ontology (2000:179-189).

Fabrega (1975) sees ethnomedical inquiry as "the study of how members of different cultures organized themselves toward medical treatment and the social organization of treatment itself" (Fabrega 1975:969). However, lest the anthropologist fall into essentializing culture, medicine, and the bodies they represent, Lawrence Cohen warns that recognizing the body as a site of historical, material, and political change,

> "...problematizes any monoglot coherence and stability of any medical inscription of the body. For, as the body and its afflictions are rooted in and between these multiple frames, the meaning of bodily knowledge is slippery. Apparent continuities in a medical tradition, in articulating knowledge of and relationships to bodies in shifting symbolic and political contexts, disguise points of deep disjuncture and conflict" (1995:321).

One student, Carole, initially displayed visible irritation at Dr. Kaviraj at the beginning of the workshop. She felt Dr. Kaviraj misunderstood her questions, consequently providing what Carole considered less than satisfactory answers. However, over the course of the month, Carole's visible irritation turned into respectful admiration, as a result of her interactions with Dr. Kaviraj.

As the month progressed, Dr. Kaviraj's depth of knowledge, experience, as well as her youthful, optimistic personality, impressed not only Carole, but also the entire class. Most class members had not before experienced in their Ayurvedic learning such Ayurvedic, Hindu, and Buddhist scholarship in the form of a South Asian trained female instructor. While their Ayurvedic academic cohorts and client bases have always been predominantly female, it should be noted that their pedagogy has not been.

The three foundational texts of Ayurveda: Charaka Samhita, Sushruta Samhita, and Ashtangahridaya, were all written by males. There are no secondary or tertiary texts in Ayurveda written by women. The cultural and medical epistemology of Ayurveda has always been androcentric; Ayurvedic pedagogy in South Asia has traditionally been in the hands of males.

Likewise, only one Ayurvedic student or graduate at the workshop learned Ayurveda from a female instructor previously. Dr. Kaviraj provided a tonality, a

resonance, amongst the attendees that communicated Ayurvedic epistemology through the shared gaze of the female healer.

Cultural Epistemes and Social Cognition

Archer's emphasis on doing over being, van Gennep, Turner, and Kakar's stressing of liminality in promoting epistemological and ontological change, and Dr. Kaviraj's ability to resonate with the students through the shared gaze of the female healer, together lend coherence to Lave and Wenger's work on Legitimate Peripheral Participation (LPP). In this model, cognition is not so much about skill acquisition as it is about increased participation in a community of practitioners, entailing a movement from peripheral to full participant (Lave and Wenger 1991:4).

Recent work suggests that the mind is both a social product and a social force (Morgan and Schwalbe 1990). However, the question of what is *social* about social cognition has received little attention from social scientists (Fiske and Taylor 1984; Forgas 1981; Lau and Sears 1986; Morgan and Schwalbe 1990). Psychologists have tended to approach the study of individual cognition in a structural vacuum that ignores the influence of the social environment (Morgan and Schwalbe 1990:148). If thinking is environmentally "framed and referenced" as Morgan and Schwalbe suggest, or "situated" according to Jean Lave (1988), then Ayurvedic cognition for western students must necessarily be dependent upon the social context in which cognition occurs, and according to the objects and problems faced in their daily lives. We see this situated learning take place as students struggle with the preparation of herbal formulae.

Back To the Kitchen, or Back to the Future?

Between afternoon and evening sessions, students talked about the challenges they faced in maintaining client compliance, which they viewed as essential to increasing a client base. None of them, mostly graduates of a California Ayurveda school, knew how, or had sufficient confidence to, create Ayurvedic formulas in their own kitchens. Ayurveda has a vast repertoire of herbal preparations designed to stabilize the herbs for long-term storage, and as important, make them more palatable. Additionally, since diet is considered a treatment modality in itself, the science of Ayurvedic nutrition is virtually inseparable from the Ayurvedic art of cooking.

Later in the month, these students' relationship to the kitchen would be more emphatically demonstrated, posing questions of women's liberation and estrangement from the hearth. Are postmodern women able, or willing, to transform the stigmatized space of the kitchen into a liberating one? How do epistemology and ontology precede this new sense of agency?

The answers to these questions were confounded by later being informed that the students from the local Ayurveda school were being charged extra fees beyond tuition in order to learn hands-on Ayurvedic pharmacology. These students found themselves in a situation where the choice between learning Ayurvedic materia medica and pharmacology depended on their ability to pay extra fees. Those present said they naturally assumed that this component of their training would be covered by their regular tuition.

In a free market where information is always a contested product, in this case both as educational access and professional ability, the students must play the game. If they do not, their Ayurvedic knowledge base and professional efficacy will be severely limited. Several of the students were embittered over the experience. Along with two other informants, they could not afford to enroll in the course, and were concerned about their academic preparation in the area of Ayurvedic pharmacology.

Towards the end of the month, Dr. Kaviraj held a Saturday afternoon practicum on the preparation of purified sulfur. The setting was the kitchen of the Ayurvedic pharmacy run by the Alta Marianna Center. Sulfur was heated and melted in large metal spoons, to which clarified butter was added, the resulting mixture then cooled by dropping into vessels containing milk. The milk was next poured through a cheesecloth-lined funnel, which captured the cooled and resolidified sulfur. This process was repeated twice, after which the sulphur was rinsed in cool water and left out to dry completely.

Dr. Kaviraj said that this purified sulfur could be used as an ingredient in alterative, or blood-purifying formulas containing herbs, without causing the negative reaction know to occur for some individuals taking sulfa drugs. What was interesting about this practicum was the formation of the class position-wise in relation to distance standing around the stove. The older students were closest to Dr. Kaviraj and the stove, eagerly participating in the melting of sulfur, pouring of clarified butter, pouring and straining milk, and rinsing the resolidified sulfur. The younger students, those in their mid to late thirties, stood away from the stove, rimming the walls of the kitchen, engaged

visually with their notebooks. Interestingly, it was the younger students who had earlier mentioned not being engaged with or comfortable with the idea of preparing their own Ayurvedic formulas at home. They seemed content to buy or prescribe formulae available on the market.

Agreeing with Lyons and D'Andrea (2003), Dobres and Hoffman (1999), Lechtman (1977), Lemonnier (1986), Pfaffenberger (2001), van der Leeuw (1993) I submit that technology is both a functional and a social product. Connections between technical activities (such as cooking or preparing formulas using various instruments, heat sources, hearth types, and vessels), material products, and social coordination of labor is what Pfaffenberger calls a "sociotechnical system" (Pfaffenberger, 1992). These activities have historically been marked by gender roles and identities (Childs, 1999; Dobres, 1999). In the workshop group, historical changes in identities and gender roles are possible factors influencing student/practitioner interaction with pharmacological processing and technical aptitude. However, what is clear are the effects of history and gender politics in contributing to practitioner epistemology, not only in the West, but by inclusion, epistemology across cultures, across medical systems. Sanskrit, the medium of preserving and transmitting Ayurvedic epistemology, will be discussed in the next section.

Whither Sanskrit?

As Langford (2002), writes, many Westerners tend to use knowledge of their personal Ayurvedic constitutional body type in order to deepen individuating patterns, a process validated by Western culture and society. The Ayurvedic students'

epistemological processes appeared quite individual and personal. Ayurveda equally stresses discourse with colleagues, professors, texts, and personal experience: the four pillars of building practitioner knowledge. Epistemic challenges in the form of academic demands and pressures are perhaps insufficient to take these students outside of their putative boxes and into a different realm of possibility, a different medical gaze upon reality.

Wujastyk (1998), Zysk (1993, 2000), and Zimmermann (1999) have shown that Charaka and Sushruta Samhitas were compilations listing practices and ideas that were in existence for centuries, many of which originated in pre- and non-Aryan practices and peoples. Sanskrit memorialized these practices: exclusive access to literacy was restricted to the highest caste that professionalized it and proceeded to declare it sacred; state power and patronage legitimized it.

I asked Dr. Kaviraj whether Ayurveda could be learned without knowledge of Sanskrit. She said that its "depths were unfathomable without Sanskrit. Only its surface would be skimmed." Such an intellectual environment, in Dr. Kaviraj's opinion, is commercially advantageous for authors writing secondary texts in English and other Western languages. She said she herself tried using the books of a popular American Ayurveda author in her classes. "It only created confusion because in many cases, meaning was lost when the Sanskrit term or phrase was translated. I had to teach everything all over again."

One student, Carole, however, took umbrage with my question, and Dr. Kaviraj's belief, as to whether or not knowledge of Sanskrit was necessary to effectively learn Ayurveda:

> "Some of us have careers, families, and other interests that demand a lot of our time. We all just can't become hermits, go live on a mountain, and learn Sanskrit. Dr. [the head of the local Ayurveda school] provides a learning environment where people from our culture can learn in the ways we are most comfortable. Whether using PowerPoint or other technology, we can learn enough Ayurveda to help most people. We are Americans who feel that Ayurveda is our dharma [duty], and that we have the right to become Ayurvedic practitioners."

In that moment, I realized that I was not listening to an American articulating her sense of entitlement, as I was listening to someone articulating a historically new sense of agency. New healing epistemes made available through global commercial networks, bodies and needs, voiced their existence through this individual. Linguistic particularities such as Sanskrit quite possibly are not as relevant, nor could they be, to the realities and exigencies of her life. However, Carole was one of the local Ayurveda graduates whom, as of yet, had not learned pulse diagnosis; nonetheless, she was applying for a faculty position at the local Ayurveda school.

However, Marlene, who had traveled and studied in the US and India, had a different view of Sanskrit is a teaching medium,

> "I believe the main concepts can certainly be delivered in any language. However, there is something about transmission by Sanskrit, which is important. I used to BEG Dr. Lad to give us more Sanskrit, for I have a deep feeling that it is in Sanskrit that the process unfolds most properly. I feel it in my bones that this is the way to go, and to force Ayurveda into English or other languages is a poor substitute for the transmission. It was only years later when reading the texts on my own that I could figure out that Dr. Lad's lectures were usually three to five sutras [verses] that he was simply unpacking in English for us, tricky

dog. I had always been amazed at how he could breeze in from his early dinner, come right into class, digest a bit with our mantras, and then lecture for two or three hours without notes. But once you know the sutras you can see how it's pretty damned easy to do the same thing – not to diminish his specialness or charming style of presentation, nor his incredible artwork. But once you have access to the Sanskrit, I think a deeper connection to the tradition is there - and certainly a more, full lecture-in-an-instant capacity!"

However, literary and pedagogical proficiency do not ensure cultural relevance. Pollock (2001) examined the historical life, "death," and modern political resuscitation of Sanskrit. Sanskrit's inclusion by the nascent State of India as a national language in 1949, guarantees it all of the benefits given the other spoken languages (Sanskrit is a literary language). State recognition translates into government funding for Sanskrit colleges and universities, under the auspices of a new national organization aimed at promoting Sanskrit scholarship. Today the level of Sanskrit teaching and scholarship has demonstrated a steep decline from pre-Independence standards. Pollock notes that the decline has occurred inversely to the proportion of funding given – as funding increased over time, scholarship declined (2001:392).

What Pollock finds bemusing is the fact that Hindu right-wing efforts to resuscitate Sanskrit ignores the fact that historians have no clear understanding of whether, or if, and if so, when, Sanskrit culture ceased to make history:

"...disparities between political inputs and cultural outcomes could be detailed across the board. What it all demonstrates – the Sanskrit periodicals and journals, feature films and daily newscasts on All-India Radio, school plays, prize poems, and the rest may be too obvious to mention: that Sanskrit as a communicative medium in contemporary India is completely denaturalized...Government feeding tubes and oxygen tanks may try to preserve the language in a state of quasi-animation, but most observers would agree, that, in some crucial way, Sanskrit is dead" (2001: 393).

For our purposes, Pollock reminds that the creativity generating new communication is just as important as the facility of that communication to transmit new information. If Sanskrit is a "dead" language, then whence the contemporary vitality of Ayurvedic pedagogy in Sanskrit? Is it doomed - to play the role of information transmitter of essentialized and decontextualized epistemes preserved, in Pollock's words, "a state of quasi-animation"? Linguistic creative imagination is an important indication of a language's capacity to function as a carrier of the social energy that fuels it (2001:394). The historical development of Tibetan medicine is emblematic of how social energy when harnessed by local vernacular language and state power, created a vibrant medical system. Therefore, benefit might be profitably obtained here by looking at the historical development of Tibetan medicine.

Tibetan Medical Beginnings

Having both Ayurvedic and Sanskritic founding elements, Tibetan medicine was energized with the unique social, political, and epistemological energy of Tibetan culture and society. Tibetan medicine is said to have its historical origins in a medical conference called by King Sron-btsan sgam-po in the 7^{th} century A.D. Summoning doctors from India, China, and Greece, King Sron-btsan requested translations of the principal works in each physician's respective medical traditions, and finally, a composite synthesis of them all. This text became known as the Mi'-Jigs-pa'I mts'on-chha (The Weapon of the Fearless One), seven chapters in all. Subsequent royal invitations to eminent physicians from Kashmir, China, Persia, and Nepal resulted in translations of foreign medical epistemologies and practices into the Tibetan

language. In relating this medical history, Bhagwan Dash stresses that the epistemological template used for understanding and translating these diverse medical systems was that of Ayurvedic medicine (Dash: 1976:49). Wujastyk, Zimmerman, as well as Dash, among others, credits the Buddhist diaspora from the Indian subcontinent to Tibet, in the persons of monks, for the introduction of the Ayurvedic epistemes that took root in Tibetan medical thought. In this medical syncretism, for example, Greek, Persian, and Chinese elemental concepts and categories of meaning were subsumed by Ayurvedic elemental constructs of ether/space, air, fire, water, and earth. However, though Tibetan medical epistemology originally used an Ayurvedic, or Indian lens, over time Chinese influences became predominant. This may have been in part due to cultural and social factors. Amber and Babey-Brooke argue that Tibetan (read: present-day Tibet, Ladakh, Bhutan, Sikkim), Nepalese, Chinese, and Mongolian social and kinship structures were more similar to each other than they were dissimilar to Hindu kinship and social structures (Amber and Babey-Brooke 1966:50). It is also possible that Hindu notions of purity, vegetarianism, and caste were incongruent with the Tibetan realities of climate, altitude, flora, fauna, and social organization.

Linguistic borrowings from India were also part of King Sron-btsan's program of Tibetan cultural development. He commissioned Thonmi Sambhota to develop the Tibetan alphabet. Sambhota, who had studied in India, based the new alphabet on Sanskrit Devanagari letters (Rinpoche 1976:15). The king's wife, a Chinese princess, introduced a text from China, the *Great Analytical Treatise on Medicine*, which was translated into Tibetan. Around the end of the 7th century C.E., King Sron-btsan began

the local teaching of this new medical synthesis and the first two doctorates were awarded at that time (Rinpoche 1976:15). For the next three hundred years, India, China, and Persia continued to enrich Tibetan medicine, both through the summoning of great physicians from those countries, and through the efforts of Tibetan medical students who traveled to these countries to learn medicine there.

Tibetan Medical Epistemology

As mentioned before, Tibetan medical epistemology closely follows that of Ayurvedic medicine: Ayurvedic Panchabhuta (Five Element) theory and their biological and physiological organizations, represented by Tridhatu/Tridosha theory (Vata, Pitta, Kapha) (Sachs 1995:25-30). Individuals are classified physically by constitution exactly according to Ayurvedic Trifocal categorizations and representations. Examination of the patient by urine, stool, pulse, tongue, nail, and physiognomic analysis are diagnostic methods also appropriated from Ayurvedic antecedents. The seven bodily tissue elements of Ayurveda, Sapta Dhatus in Sanskrit, are also included in Tibetan medical epistemology.

Mental and psychological states of being as well as imbalance are based on Ayurvedic and Yogic notions of three states of awareness, namely, Sattwa, Rajas, and Tamas, or Pure Awareness, Action, and Ignorance, which are given a uniquely Buddhist interpretation as consisting of the stages of awareness representative of liberation, karma, and bondage respectively. These mental states are seen as provocative of either illness or health. Therefore, Buddhist practice is seen as a means of cultivating health through awareness, an objective consistent with the ideals of the best public health campaigns

(Sachs 1995:205-212). Standing in contradistinction to Indian culture and its caste restrictions, Buddhist tools and goals of spiritual practice were made available to all Tibetans. Medicine is seen as an indispensable part of spiritual growth, "The principle source, from which benefits for the world and Nirvana can both be derived, is the science of medicine."(Rinpoche 1976:31)

Modern Political Influences on Tibetan Medicine

Political factors shaped (Badmaev 1999:252), and continue to shape (Kressing, 2003; Comtex, 2003) the evolution of Tibetan medical practice. The hegemonic power of the Tibetan Empire between the 7th and 9th centuries, which extended from the northern Indo-Gangetic Plain northwards towards Samarkhand in Central Asia, combined with the spread of Buddhism, was symbolically and historically represented by the conversion of the Tibetan King and nation to by the Buddhist saint Padmasambhava. This event precipitated a politico-religious amalgam that lent social, cultural, political, and spiritual authority to a nascent Tibetan medical construct. The medical systems of Bhutan, Ladakh, Sikkim, Nepal, and Mongolia today owe their existence to these historical events and the cross-cultural movement of ideas, sacralizing tropes, and political agencies they represent.

After almost a century and a half of imbibing foreign influences into the local model of medical learning, Tibetans began a seven-hundred year process of refining and indigenizing their medical system, beginning with the establishment of the first Tibetan medical college in the 8th century C.E. in Lhasa, the Kong-po-menlung. Subsequent medical colleges were established in the 17th century and in 1915 (Badmaev

1999:253). It is important to note that since the Chinese invasion and occupation of Tibet, the Tibetan Medical Institute in Dharamsala, India, was established in 1959 under the auspices of the exiled Dalai Lama, the recognized patron of medicine in Tibetan culture. There are currently three centers of formalized instruction in Tibetan Medicine: in Lhasa, Tibet; Thimphu, Bhutan; and, the TMI in Dharamsala, India.

Tibetan Medical Practice in the West

It could be argued that Tibetan medicine is perhaps the most religiously bound system of literate medicine practiced in the world today. The guarded repository of Buddhist monks, Tibetan medicine is inextricably tied to Buddhist canon, lore, psychology, and philosophy. It does not travel except through the agency of monks and nuns. Therefore, Tibetan medicine's existence in the West is unalterably connected to the establishment of Tibetan Buddhist sanghas, or communities of monks, nuns, and their lay followers in Europe and North America. Tibetan monks and nuns who practice medicine do so within the context of a lived existence that does not depend on capitalistic exchanges in order for the medical practice to survive. Their social, moral, and spiritual authority lends cultural validity to their medical practice, a sacralized professionalism. It is in this light one understands that Tibetan medicine travels as a necessary, but complementary part of the Tibetan clerical body – distinct, but not separate, from it.

The religious structure of which Tibetan medicine is but a part, most likely explains to a great extent why Tibetan medicine has remained off the radar screen of CAM therapies popularly advertised and competing for the attention of an ever-growing population of CAM health care consumers and political and legislative bodies.

Citizens of a province of the People's Republic of China, Tibetans today inherit a traditional medical system experiencing change due to hegemonic political forces, which in a sense, is not an historical anomaly. The difference today however, is that of power radiating from Beijing to Lhasa, not from Lhasa outwards. The desacralized, demystified, Han Chinese model of nationalistic medicine is slowly engulfing Tibetan medical practice in Tibet. The eleven state medical teaching centers of Chinese medicine are gearing up to begin the process of subsuming Tibetan medicine into the medical body of the Chinese nation-state (Comtex, 2003).

However, the historical continuity of Indian and other Subcontinental influences upon Tibetan medical practice, even as it travels to Siberia back towards Europe, or across the Pacific to the Americas, is a testament not only to Tibetan medical continuity, but also of social, religious, cultural, and trade continuities. These continuities challenge culture-bound scholarly approaches to the study of history, culture, religion, and medicine, as limiting exercises in reification that obscure much more than they reveal.

The future of Tibetan medicine is bright, given the increase in popularity and growth of Tibetan Buddhist practices and sanghas in the West, the name recognition and goodwill engendered by the diplomatic and humanitarian efforts of the Dalai Lama; and, the embeddedness of Tibetan medical practice within the religious culture of monks and nuns. Pragmatically, what might prove even more contributory to Tibetan medicine's acceptance in the West is implied in the preceding sentences – Tibetan medicine as a sacralized construct within Tibetan Buddhism. The Dalai Lama's moral authority in the West, combined with an organized, professional class of practitioners in the persons of

the monks and nuns themselves, might prove more legally palatable to political entities in Europe and North America charged with regulating CAM therapies, than other healing practices such as Ayurvedic medicine (ironically, its progenitor).

From the preceding, it is clear that superimposition of an ossified Sanskrit onto the vibrantly dynamic present of not only Euro-American societies, but Indian society as well, may serve well the purpose of conveying information. What is not denied is the informational value and historical preservation of the Ayurvedic corpus through its inscription in Sanskrit – what is questioned however, is its capacity to enliven a now globalized contemporary Ayurvedic discourse and pedagogy in a manner that reflects the *zeitgeist* of whatever cultural context it seeks to address and represent.

Institutional, scholarly, pedagogical, and practical decay of Sanskritic and Ayurvedic traditions in India today has found new life in the form of growing international interest in Ayurveda. The recent National Ayurvedic Medical Association's 2004 convention aboard the Queen Mary in Long Beach, to paraphrase Cohen, symbolized Ayurveda's movement into globalized, luxury space, affirming the cosmopolitan sophistication of Indian practice, while validating the presence of North American adherents' attempts to speak of and for a "foreign" cultural episteme, Ayurveda (1995:329).

The example of Tibetan medicine shows the historical flexibility of Ayurvedic concepts and practices in adjusting to new political, cultural, medical, and environmental conditions. This suggests that Ayurvedic pedagogy and practice in the West will adjust to its new surroundings and discourses as well.

The Flexible Body

The informants who spoke of their struggles making their Ayurvedic practices more successful tended to blame themselves for attracting smaller than expected clienteles. According to Carole, personal development through yoga, Ayurveda, and massage training, "makes me feel like I've done everything right, but I'm still waiting for the universe to acknowledge this". Is something vital being missed here? Should this research narrative focus on Western students as practitioners in training, or as individuals focusing on practicing new skills to become more "flexible," to use Emily Martin's (1994) term? Martin argues that "flexibility" has been normalized by political and economic discourse into a desirable and cultivatable psychological, physiological and organizational trait achievable through *training* and *education*. Differential access to resources makes access to training and education inherently unequal. However, the real objective of training and education is to prepare one to successfully adapt to and survive constant change. Hence Martin's notion of *flexibility* (1994:15-17).

This fieldwork made it clear that personal growth and change took precedence over notions of using Ayurveda solely as a vehicle for professional accession or economic gain. However, most informants tended to view personal growth as a prerequisite for practitioner efficacy and commercial success. What Martin calls "earnable competence" was affirmed by these views, that through training and constant learning, individual growth and development occurs, resulting in financial gain (1994: 243).

Martin argues that science itself "as an active agent in a culture that passively acquiesces does not provide an adequately complex view of how scientific knowledge operates in a social world" (1994:7). She claims to demonstrate that great shifts in the social knowledge of the immune system, the logic of health, sickness, and fitness for survival in terms of how they are seen in the social arena. The immune system and its ability to adjust to change spontaneously in the face of uncertainty, is the locus of Martin's exploration of how people adapt to the economic, environmental, and biological challenges of modern life (1994:13).

Using the body as metaphor, Martin writes about recent changes in American culture concerning the meaning of work, the body, and identity. From government policy to new age practices, "flexibility" is the new catchword for human survival in the Post-Fordist world. If any contemporary phenomenon supports Martin's arguments, it is the language of discourse around health insurance and unemployment in the 2004 Presidential election. George Bush constantly invoked the word "flexibility" in describing the adjustments and sacrifices the working class must make in order for US business to remain "competitive" in the global marketplace. In this respect, Martin's claims are not only warranted, but spot on.

Furthermore, overlooked by my informants was the larger legal context for the practice of Ayurveda in California. To understand that context we need to examine the larger political and legal framework in the next chapter.

Chapter Four

The Pragmatics of Practice

Diverse voices within the Ayurvedic community in California reflecting diverse educational and epistemological backgrounds are engaged in debate about how to best unify and legalize their profession without compromising Ayurvedic ontological values. While Chinese medicine has undergone this legal process in California, and there is much literature chronicling it, Ayurvedic medicine is the new form of complementary medicine clamoring for state licensure. Considered one of the few "civilizational," literate medical systems (the others are Chinese and Islamic), it could be argued, as it is by some, that Ayurveda's historical and empirical credentials are more legitimate and worthy of legal consideration, than newer alternative therapies that have not withstood the test of time, nor of culture. We will examine whether or not the ontological distinction granted Ayurveda by medical anthropology translates into legal capital in the state California sufficient to negotiate change in its legal status. And, is negotiating a change in Ayurveda's legal status the best way to nurture the growth of the system and protect the rights of its practitioners?

The Anthropology of Law and CAM

In Certainties Undone: Fifty Turbulent Years in Legal Anthropology, Sally Falk Moore (1990) chronicles the development of legal anthropological studies from originally a study of non-Western legal structures, to today's focus on Western local, national, and transnational legal formations. Moore sees three schools of explanatory law as the recurring themes in the fifty years of legal anthropology. First, Durkheim's "elementary

forms of social unanimity" (1961), Weber's "traditional authority" (1978), Habermas (1979), Geertz (1983), and Hoebel (1954), are seen as examples of colonial attitudes towards "customary law," which saw law as culture and tradition-driven, a subset of culture itself with internal connectivities. The Critical Legal Studies Movement (Fitzpatrick, 1987; Fitzpatrick and Hunt, 1992; Kelman, 1987; Snyder, 1981a) represents the "law as domination" school of legal anthropology charged with a Marxist style that sees the law as a tool engendering elite capitalist interests. Thirdly, the "law as problem-solver" school of legal anthropology is seen as beginning with Llewellyn and Hoebel (1954) and their book on the Cheyenne. There are many lawyers in this school.

In Laura Nader's (1969) discussion with Max Gluckman, she urges anthropologists to study the law as a culture unto itself. Nader endorses Bohannon's advocacy of the ethnographer understanding what exactly an individual society or culture thinks about their legal system, as Hoebel did in *The Law of Primitive Man* (1954). She asserts that no ethnographic process is complete unless it studies the entire sphere of legal influence from the societal level to the individual level, and the relationships between and amongst them, challenging sociological attitudes at the time that saw no hierarchical relationship between the law *and* society. Nader's point is that the law *in* society is indeed a hierarchical construct. This she urges anthropologists to study. Max Gluckman was of the opinion, however, that any study of dispute resolution in and of itself could definitely be conducted by social scientists, but that study of judicial process could best be performed using concepts from jurisprudence itself, not the social scientists. Nader questions culture bound tools such as jurisprudential epistemes, and saw Gluckman's

positions as emblematic of an unspoken uneasiness with viewing the law as a separate culture unto itself. Gluckman retorts that he does not say that anthropologists cannot study tribal law, because law in and of itself is a social science, and that its concepts could profitably add to the analysis of any anthropological inquiry. He admits that use of the legal terminology has its risks, but all ideation carries risk.

Michael Cohen (2000, 1998) looks at the legal relationships between biomedicine and holistic healing, state laws and medical regulation, scope of practice, as well as the evolution of legal authority. Using Kuhnian analysis, Cohen presents Complementary and Alternative Medicine (CAM) as a paradigmatic shift challenging not only Newton, Descartes, and the biomedical paradigm they inspired, but Western legal epistemology itself. He asserts that the legal process should ideally respect the individual's search for health, and that such legal understanding must include broader thinking than that reflected in the biomedical paradigm. Law should reflect social values and culturally validated health care practices. Cohen says this is an expansive, dynamic process:

> "Ultimately, legal authority must evolve commensurate with changes occurring in the medical profession and the marketplace. Certain trends within the law provide an argument for the evolution of malpractice law toward responsible professional integration of complementary and alternative medicine. Further, such evolution may be necessary in order for malpractice insurance to more meaningfully cover physicians' exploration of useful therapies currently considered outside mainstream medicine" (2000:31).

Although Cohen's statement was directed primarily at biomedical practice, the question of legal recognition and involvement with insurance companies is not so easily reconciled with operational reality. Cohen reminds that current legal and regulatory structures currently affecting CAM are the result of the sectarian contestation, competition, and

professional monopolies of the nineteenth and twentieth centuries. Rather than protecting biomedicine, Cohen recommends the legal system to concentrate more on protecting people searching for the best healthcare that addresses the deepest levels of their humanity. He believes that only by examining the belief systems of all involved in the debate will there be clarification, leading to laws that regulate healthcare (he uses the more empowering term "self-care") more honestly along the track of human aspirations toward wellness. Cohen says this will only occur when legal authority comes to recognize "healing" as a larger issue than "medicine." This will have the effect of recognizing healers as distinct from doctors, and give the legal space to breathe.

Ayurvedic Practice, Professionalism, and Legal Landscape of California

How is Ayurvedic medicine practiced and what language is used within the current legal environment in California? The majority of practitioners questioned at the workshop require signed consent forms by all clients seeking their services. However, not all were informed concerning the current legal situation in California. Senate Bill 577, effective January 1, 2003, relates to alternative practitioners. It stipulates that a person engaging in certain medical treatments who makes specified written disclosures to a client shall not be in violation of certain provisions of the Medical Practice Act unless they engage in specified *diagnosis, treatment or other activities* (emphasis added).[12] The statute requires the advertisement of persons relating to complementary of alternative health care to state that they are not licensed.

A workshop attendee, an endocrinologist, was of the opinion that as long as Ayurvedic practitioners inform their clients that they are being assessed according to

Ayurvedic classifications and parameters, they are legally safe. He emphasized that when an Ayurvedic practitioner uses biomedical disease terminology in the assessment (diagnosis) of an individual, then that practitioner is on shaky legal ground. Dr. Cooper also opined that Ayurveda in the West is better left unregulated by the state because,

> "Once the state gets their hands on you, they will never let go. Once a standard of practice is legally established, and the insurance companies get involved, Ayurveda will cease to be a creative healing force. This is what has occurred in biomedicine."

Dr. Cooper's views were fueled by his recently learning that the top medical malpractice attorney in his city had just announced revenues of $75 million for the year ending 2003. In such a litigious environment, only the patient suffers, Dr. Cooper avers. This is a minefield, he says, that Ayurvedic practitioners should avoid at all costs. Dr. Cooper would find support in Laura Nader, who calls the law "a study in the mechanisms of the processes of control," which are driven by hegemonic forces (2002:119-120).

Dr. Cooper and his views bring to mind of the work of Davis-Floyd and St. John, (1998) who document the epistemological changes experienced by a group of biomedical physicians concerning the body, illness, disease, healing, medical practice, and their possibilities as well as limitations. The authors examine biomedical education, the reduction of people to diseases anatomically localized, the effects of these on physician-patient relationships, as well as physicians' attitudes towards clinical methodology, as part of a process of transforming from doctor to healer. The physicians interviewed identified these epistemological and ontological catalysts as dependent variables driving a maturation process that in some of the cases presented, were acts of psychological and emotional survival. Looking at the whole person, rather than just the disease, required a

new medical gaze. Questions of life, death and meaning conflate, leaving the physician point person responsible for a coherent interpretation of them.

Interestingly, the practitioners interviewed agreed with Dr. Cooper. Notions of individual practitioner freedom, agency, and the belief that avenues for their expression already exist, inform their relative ambivalence towards state licensure of Ayurveda. Mirroring English-Lueck's observations in 1984, practitioners, ". ...prefer to practice in small, private, networks with or without official licensing, or they may choose to practice publicly." (1990:116) In their social, private, and professional *milieux*, all practitioners felt quite comfortable in their respective spheres of Ayurvedic activity. Therefore, Cohen's elucidation of an inexorable movement of CAM therapies toward greater legal recognition, and Dr. Cooper's exhortations to Ayurvedic practitioners to resist this movement, were not conscious concerns of the Ayurvedic practitioners interviewed. However, the structure and function of their beliefs and practices cohered with Dr. Cooper's views. None of them wished to be heroes or martyrs on the battlefield of political representation. Why should they? The Ayurvedic practitioners in attendance maintained practices in areas such as Marin County, Sonoma, Napa, San Francisco, Santa Cruz, Monterey, and Carmel, among other places. Ayurveda is one of many healing practices flourishing in these, some of the wealthiest areas with some of the highest levels of educational attainment, and cultural and scientific sophistication in the United States (www.jointventure.org/PDF/JVIndex2005_FINAL.pdf). Paradoxically, medical

scientific discourse holds scientific illiteracy responsible for irrational patient healthcare choices. Yet, holistic healing modalities thrive in the San Francisco Bay Area.[13]

Ayurvedic medicine in California is not a homogenous phenomenon. Naturopaths, acupuncturists, herbalists and others feature, offer, or blend Ayurvedic epistemes and materia medica in their professional practices. The California Association of Ayurvedic Medicine (founded by Dr. Solomon, the owner of the local Ayurveda school mentioned earlier) is an organization aiming to obtain state licensure in the state. CAAM's proposals for standardizing, upgrading and lengthening current Ayurveda curricula statewide, and the inter- and intra-organizational debates and discourses informing them, reflect the larger issue of political and institutional power, not only by the state, but by the various factions jockeying to gain access to the state's ear – or as the case may be, to avoid it altogether.

Patient choice and agency concerning complementary medicine has reached a stage where biomedical and legal institutions are debating how to co-opt, appropriate, or legislate complementary health practices, in a manner sensitive to patient demand and market reality. CAAM's negotiation through the legal challenges required to obtain licensure was illustrated by the election of an acupuncturist to lead the organization, after heated debate concerning the future form of Ayurvedic medical practice in California. How CAAM moves towards increasing educational requirements, professionalizing the discipline in order to eventually obtain state licensure, may determine the future of Ayurvedic pedagogy and practice in California, and possibly nationwide.

Paul Starr (1982) offers valuable insight on the mechanisms involved in professionalizing medicine and producing institutional power:

> "Science may improve the efficacy and productivity of a profession without making it rich or revered; knowledge must be transformed into authority, and authority into market power, before the gains from scientific advance can be privately appropriated by a profession...What must first be explained is how the group achieves consensus and mobilization" (1982: 144).

One informant raised concerns about who exactly is going to slice up the growing Ayurvedic pie,

> ". ..some of the crap going on in the West from Ayurveda enthusiasts (the most polite term I can use for them) scares the beejeesus out of me. ..the arrogance/ill-informed folks in [the local Ayurveda] program and his graduates, advertising themselves as specialists....the trademark-drama of Maharishi Ayurveda - where no other Ayurveda is "acceptable"...the Chinese medicine folks who feel they are the rightful heirs to bastardize it....the naturopaths who are trying to legislate that they are the only ones able to practice it....WTF?!"

The legal status of Naturopathy and Chinese medicine in California, the economic power of the TM movement, and the pedagogical niche carved out by US Ayurveda schools have created various contenders for Ayurvedic professionalization, legal representation, and market dominance. Indian and Euro-American stakeholders in this new market have also squared off in the battle of who and what will be the face of Ayurveda in the United States.

CAAM has already had its share of internal squabbles. Dr. Solomon, its founder, was voted off the board. The president, one of his former students, voted with the majority, a blow, one informant said, because he believed Dr. Solomon had an ally in this ex-student, now president. The president, in turn, found herself embroiled in a public

row with another member, who made accusations of conflict of interest and the use of the president's position for financial gain.

It should be noted that the row occurred between two female Indian practitioners, one educated in India, the other at the local Ayurveda college. While this fact is on one hand unimportant, it does raise questions concerning representations of Ayurvedic "authenticity." One informant said that some members feel "looked down" upon by some Indian members of CAAM, but particularly by these two (and another) woman. In her words, "They do the 'flip-the-sari-in-the face' as we call it, by making us feel that we aren't enough because we aren't Indian and weren't raised in the culture." Within a year, the president tendered her resignation. An acupuncturist was elected to take over the fledgling organization, to the consternation of some members, who felt that an Ayurvedic practitioner would have been a better choice. Others were of the opinion that an acupuncturist would be more aware of what needed to occur in order to obtain state licensure for Ayurveda, as acupuncture had achieved. However, as mentioned earlier, the workshop informants had no interest in participating in efforts to professionalize and legalize Ayurveda in California. Ambivalence, particularly towards professionalization, may indeed be well informed.

Brenda Beagan (2001) looks at the creation of professional identity amongst medical students from diverse backgrounds. She finds that the process of identity formation is unchanged from over forty years ago when Boys in White (1961) was published, a time of virtual cultural homogeneity in Canadian medical schools. Negotiating the medical hierarchy was seen as the great unequalizer in

facilitating medical student inculcation in the art of structural compliance, without questioning superiors. This had the effect of students learning to get along with faculty, developing a sense of professional cohesion rather than bonds with laypersons and patients. Emotional distancing from patients and learning to appear professional in the midst of therapeutic or diagnostic uncertainty are seen as important aspects of medical socialization. From the white jacket to stethoscope to the patient file, an artifice of competence is impeccably nurtured.

Beagan's article is useful in its inference that the definition of professionalism may well include notions of crafted competence in the face of epistemological uncertainty, along with the melding of the medical training cohort along the lines of hierarchal relationships. Professionalism as barrier to patient intimacy and empathy is implied in these pedagogical structures as well. Barriers to patient intimacy and empathy notwithstanding, professionalism according to Starr, is an indispensable part of gaining social and legal acceptance.

Crellin and Ania (2002) challenge both CAM and biomedical students and practitioners to respond to the ethical and legal questions created by their own epistemologies and practices. They recommend that CAM practitioners develop informed consent guidelines, as the increased popular involvement in CAM will likely cause an increase in the number of malpractice suits. A 'profession' is defined as a group with a unified agreement as to the identity of the practice that possesses a codified knowledge base transmitted through education and an agreed core curricula. A profession is also self-regulated, with social barriers of inclusion by limiting number of

practitioners, training programs, and alignment with the scientific paradigm. These elements constituting a profession are, in their opinion, necessary for the protection of individual and group interests.

However, the advantages of professionalization, as suggested earlier by Starr, find resonance with Hanlon (1998). Following Abbot (1988), Hanlon sees professionalism as an ongoing contested redefining process engaged in between different occupational groups. Cultural capital, he argues, is a source of privilege and intergenerational entitlement that professionals seek to pass on to their children. Licensure and credentialing give professionals freedom from institutional and employer constraints, allowing them to constantly improve their class position, an opportunity not available to the wage laborer. Cultural capital is separate from economic capital, in that *it is obtained and validated by society*. Therefore, for Hanlon, professional battles are cultural battles. Who determines what is cultural capital depends on who determines what skill sets or practices are deemed "important." It is in this context of struggle Hanlon defines professionalism, and as suggested by this research, indicates that Ayurveda in the United States has space in which to grow, filling new cultural interstices of patient, client, and consumer want and need.

Starr connects US medical professionalism to its historical antecedents in colonial Britain, where medicine's place atop the social structure mirrored the hierarchal character of the society itself. Starr describes professionalism as an inequality claiming a dignity not shared by ordinary occupations, with the right to set its own rules and standards. Starr points out that this claim goes against democratic principles. In this

light, Starr perceptively states that popular resistance to professional biomedicine is not due to hostility to science or modernity, but to its undemocratic nature.

Starr and Hanlon's analyses of professionalism detail how a profession must groom itself if it is to acquire social, cultural, legal authority. Charges of undemocratic and self-serving conduct in CAAM demonstrate that Ayurveda in California is not immune to the intrigues of power and perceived inequality. If Ayurveda is to become ensconced legally within the State of California and the nation, one can only expect such theatre to continue.

Chapter Five

Anthropological Perspectives

This work suggests epistemological breaks and cognitive dissonance might occur between Ayurvedic practitioners depending on their points of origin, academically, or natally, regarding how Ayurvedic pedagogy and praxis in California. It also suggests that epistemological and ontological dissonance between practitioners and American patients might occur and require further examination. Another possibility of note is whether, and if so, how, meaning and context might be lost or diluted in the cross-translations and retranslations of cross-cultural language and content. However, in the broader contexts of this discourse, I argue that is not new in the history of the Ayurvedic diaspora.

Convincingly suggested by this fieldwork is the power of liminality in effecting epistemological and ontological change. The students observed and interviewed appeared insufficiently challenged beyond the comfortable; on the other hand, their ongoing pedagogical relationship with Dr. Kaviraj, the first female Ayurvedic physician they had learned from, suggests a mutual overlapping of commonality conducive to greater epistemological intimacy. Liminal spaces, this research argues, cannot be bought.

Furthermore, the primarily female composition of workshop attendees, 95% upper middle-class white Americans, sincere in their quest for a deeper understanding of themselves and their world, suggests that this is a contested cognitive, cultural, and social process. Seeking to learn a practical Ayurveda useful within the American cultural context, devoid of mythological and linguistic particularities, it was evident from class exchanges that the Ayurveda they wish to practice honors their individual and collective

learning trajectories and cultural values. They wish to make a difference, in their own lives, and in the world. Yet they are attempting to learn and practice in a world where the market always has its say in how they are educated, as well as how they manage (or exploit) that education. Money, on a base level, is not what drives them.

Yet, this fieldwork suggests that education, wealth and class enable patient choice and practitioner agency. In this case, legal change becomes superfluous, redundant in an environment where cultural change buttressed by social capital has already occurred. If culture is invisible to its members, the same might be said of power, and the social capital that it provides. None of the informants recognized Ayurveda as an historical product of politics or hegemonic impulses.

The aforementioned, however, poses questions of social inequality and economic segregation in complementary and alternative medicine. Since no practitioner interviewed had a full-time Ayurvedic practice, and since insurance remittances were not an option, seeking patronage from upper-middle to upper-class clients becomes almost a law of nature, or a law of the market.

Questions of gender representation also were elicited from this fieldwork project. One attendee was of the opinion that the relative absence of men in the workshop is illustrative of men's use of time and information mostly in calculated, pragmatic, bottom-line terms. "Women," she said, "Understand how change occurs without external influences like money and power, and we're more patient with it."

Once despised and ridiculed by the British as a weak, effeminate product of a debilitating vegetarian diet, the traditionally disciplined Indian body now has value in the

West as a symbol of health and healing. A product of the largest nation on earth never to have won an individual Olympic gold medal, this body is the culturally constituted entity whose constructs of the body, mind, and soul are today well ensconced in the American milieu of health and "big money, big money." In a world where most peoples of color's cultural knowledge and practices have been denigrated, suppressed, marginalized, or struggle to survive, this is indeed a most remarkable accomplishment. However, as we have seen, Ayurveda and Yoga as postmodern cultural and commercial products are the contested results of history, power, and hegemonic influences.

In India, Ayurveda is promoted within a populist Hindu scientific nationalist discourse that subsumes Islamic, Siddha, Homeopathic, and Naturopathic medical systems within a primordialized, ahistorical, Ayurvedic construct, which infers marginality to minority cultural, national, and religious communities. At the same time, it confers inferiority upon the "foreign" medical epistemologies espoused by these minority communities. In effect, reified notions of an imagined traditionality projected onto the masses by the linguistic, religious, medical, and scientific nationalisms imagined in their name, become political capital in the hands of national elites.

Yet, Ayurvedic education in India today produces mostly degree holders, not clinicians. It has been estimated that around half of all Ayurvedic M.D. theses are bought from professors for around $13,000 US (Langford: 2002:132). As was mentioned earlier in the outline of Ayurveda's early history, there was a time when the shaman was supplanted by the empirical practitioner. In due time, the empirical practitioner was replaced by the Sanskrit scholar, who codified and systematized the body of empirical

medical knowledge. Today, the Ayurvedic scholar is being replaced by the degree holder, an individual with little background in Sanskrit, who moreover someone with possibly dubious Ayurvedic knowledge and credentials. Therefore, it would be disingenuous, in light of the evidence, to assume any epistemological, ontological, pedagogical, or cognitive advantages of Ayurvedic education in India today over the capabilities and possibilities for Ayurveda's development in the West. The problems in Ayurveda are internal and not contained within any perceived threats or discourses of cultural, epistemological, or even capitalist contagion from the West. It also hints at the fact that Ayurvedic students in the West can learn the system, and are perhaps more motivated to do so than are students in India living in the throes of technology-driven globalization and the wealth generated from access to globalized systems of knowledge and production.

Historically, interaction with Greek, Islamic, Tibetan, Siddha, British, and tribal medical epistemes and practices continued to enliven Ayurvedic practice. Trade with Central Asia, China, the Himalayan kingdoms, Persia, the Portuguese, the East Indies and most of the circum-Indian Ocean area over the centuries added to the material medica of Ayurveda. It can be argued that Ayurveda, as a textual construct of the 3rd Century BCE - 6th Century CE, was, and is, an index of its times and can only be read with an understanding of the dynamism of history, and by extension, its medical practices. Dr. Kaviraj contends that Ayurveda "is not a panacea. It cannot cure everything. Yoga, Ayurveda, biomedicine, Chinese medicine and acupuncture, we need them all."

How does this inform us concerning Ayurvedic education in the West? One answer might be found in the dialogue between the self of Socrates and the self of Ayurveda; what each gives it also has the power to take away. One encourages intellectual unconformity, even to one's teacher, the other, surrender to the teacher and the teachings. It is an interplay between culturally-constructed selves that can inform as much as it can misinform. Yet, this dialectic is an inescapable and necessary component of Ayurveda's adaptation to Euro-American spaces, discourses, and epistemic-induced physiologies.

Gregory Bateson's (1958) *ethos* and *eidos*, or standardized emotional and cognitive cultural constructs, if his hypothesis is correct, reinforce each other by creating an environment of conformity, which, " ...the pervading characteristics of the culture not only express, but also promote, the standardization of the individuals" (Bateson 1972:83). Durkheim's (1982) hypothesis that social facts precede individual agency informs my reading of Bateson, for the purpose here of looking at pedagogy, epistemology, and ontology within the context of examining the process cross-cultural cognition of Ayurvedic ethos and praxis in the West. Conscious of the essentializing potential use of terms such as ethos, eidos, cultural configurations, even "Ayurvedic praxis", this work recognizes these terms only in as dynamic a sense. Raymond Williams states, "...hegemony is almost never complete" (Williams 1976:109), suggesting here that Ayurvedic medicine in the West will most likely "reauthenticate" itself, as it has in its two millennia journey north, east, west, and south from the Indian subcontinent. Therefore, modern Indian right-wing political ascriptions of Ayurveda as

an autochthonous Hindu science betray the dynamic history of the medical system. Sanskrit as a living language struggles to survive in post-Independence India, kept artificially alive by right-wing Hindu nationalist interests. As a pedagogic instrument, it exists today in a state of scholarly decline. What cannot be denied or left unappreciated is its informational, historical, and grammatical value, as well as being a repository of human knowledge, thought, and experience. However, Ayurvedic pedagogy is related to epistemes that assume that the body it maps is an ahistorical, universalized construct.

Bateson's *ethos* and *eidos*, Scheper- Hughes' body praxis, both informed by history, transmitted through society, and somatized therefrom by all, shape the cultural form of healing required. Consequently, they also shape the modes by which this new form of healing must be taught, if it seeks to acquire any form of social capital, relevance, recognition, and most importantly, therapeutic efficacy. This work argues that pedagogic, much less therapeutic efficacy is by nature a social efficacy, informed by the somatized social facts of any given society: it is in these educational and therapeutic spaces that "authentic" and "correct" forms of healing become validated, inscribed as new social facts. Therapeutic efficacy is in purpose and action a mediated efficacy. Its articulation is a pedagogical transmission of knowledge as well. Therefore, in order for any medical pedagogy to be therapeutically effective, it must be informed by the somatized history of its society.

In this manner, hegemony is constantly contested, as Paul Starr reminds concerning biomedicine's struggle to achieve professional status, legal recognition, and institutional power in the 19th Century, which he argues holds true today:

> "If the medical profession were merely a monopolistic guild, its position would be much less secure than it is. The basis of its high income and status, as I have argued all along, is its authority, which arises from lay deference and institutionalized forms of dependence. The private interests of physicians alone would be insufficient to sway the society had they been unable to satisfy the felt need of others. The strength of classes, as Polanyi has written, depends 'on their ability to win support from outside their own membership, which again will depend upon their fulfillment of tasks set by interests wider than their own.[14] This was exactly so for physicians, who, alone, had little power. With widespread support, which they received because of complex changes overtaking the entire society, physicians were able to see social interests defined so as to conform with their own. This was the essence of their achievement" (1982:144).

Ayurveda and other complementary systems of healing are today positioned to engage in the socio-cultural *mêlée* required to garner public support and legal recognition. Complex changes in society today, as before, continue to change the articulation of medical demand and medical practice, and by extension, medical representation in the form of newer healing epistemes and practices.

Basham, Tharpar, and Zysk remind of the epistemological and cultural adaptations Ayurveda made as its adherents moved throughout India, to Sri Lanka, Tibet, Southeast Asia, and China. Historically, this literature suggests continuity - that the US is the latest stop in Ayurveda's movement globally over the last two millennia. Epistemological change then, is not new, nor is cultural adaptation, in Ayurvedic history. If there are epistemological and ontological splits in CAAM based on cognitive dissonance rooted in essentialistic thought or epistemological differences, this

research argues that they should be seen within the context of an historical continuity and process of cultural adjustment.

While the 'meaning' of Ayurveda as a "Hindu" scientific episteme was not challenged by the students, successfully 'doing' Ayurveda within their societal spheres of involvement required, in their opinion, a cultural relevance that took primacy over, but not completely supplanting, "authentic" Ayurvedic epistemes. Ayurvedic epistemic utility comes from its ability to generate new discursive knowledge applicable to the practical knowledge base of that society. That knowledge base contains its own embodied knowledge, which informs the psychosomatic praxis of the individual and his or her societal normative assumptions, semiotics, and discourses.

Dr. Kaviraj recognizes the need for a medical system to be relevant to the society it which it seeks to serve. She also recognizes, as a non-westerner, how some modern cultural constructs misinform, engender physical and psychological dependency and insecurity, and somatize social inequality, particularly through mass media. American students of Ayurveda who are able to strike a balance between establishing an ongoing cultural translation process of Ayurvedic epistemes with their own cultural notions, while recognizing that bodies and ways of understanding them are historically, politically, and ideationally informed, may well be the best positioned to benefit from the exchange. Ethnocentrism, either from South Asian or South Asian-trained practitioners, or from Euro-American students enamored with their own group epistemes, will not enhance or improve the discourse of Ayurvedic pedagogy or by consequence, social relevancy within local spaces. This work has demonstrated how ethnocentrist impulses

have historically had a negative impact on Ayurvedic pedagogy in India. This historical precedence, its attendant instructive lessons for the present, and opportunities for the future provide sage counsel for present stakeholders and other social actors.

Embracing the preceding in offering a differential diagnosis of the whys and hows informing Euro-American attraction to Ayurvedic epistemes is Martin's notion of *flexibility*, which sees continual training and education as indispensable to personal and economic survival in an age of biological, economic, and organizational uncertainty. This research avers that individual agency as such is conditional on the individual's concept of the possible, oftentimes in contradistinction to scientific and institutional dogma. In addition, these same institutions have the power of shaping discourse to the extent of influencing individual agency by reshaping organizational structures and objectives. In this sense, Martin subscribes to Durkheim's views of social structures, actors, and agency. The difference for me was the realization that this ethnographic research was a sociological work as well as an anthropological one, for it is bounded by American epistemes of immunity, the body and flexible citizenship, which might not be applicable to other cosmopolitan societies.

This research demonstrates the importance of history in the formation of social and scientific knowledge, whilst being mindful of their culturally bounded assumptions and limitations. Individual agency as an initiator of subjective change can be considered suspect under shadows cast by overarching structures of hegemonic discourses casting chimerical offers of personal choice, freedom, health, a competitive edge (read, *survivability*) under the rubric, the trope, of *Ayurveda.*

Notes

[1] Pseudonym, as are all informant, participant, and fieldwork site names in this work.

[2] J. Filliozat, The Classical Doctrine of Indian Medicine: Its Origins and Greek Parallels Delhi: 1964).

[3] See Chakrabarty, Subaltern Studies and Postcolonial Historiography, p. 12.

[4] See Paola Bacchetta 1999. Militant Nationalist Women Reimagine Themselves, pp. 1-14.

[5] See Suvendrini Perera 1999. She writes eloquently concerning the militarization of women in Sinhalese and Tamil communities, colonial construction of "Aryan" and "Dravidian" categories and their lethal postmodern effects, as well as the underlying cultural syncretism of a shared life experience betrayed by political, religious, and military agents.

[6] Drugs Control Department, Government of India. Drugs and Magic Remedies (Objectionable Advertisements) Act, 1954. http://www.kerala.gov.in/keralacallfeb04/p18-19.pdf. Accessed 05/28/04.

[7] See Government of India (Ministry of Health). Report of the Committee to Assess and Evaluate the Present Status of Ayurvedic System of Medicine [Udupa Report]. New Delhi: Government of India. 1959, p. 8. As cited in Jean Langford, *Fluent Bodies: Ayurvedic Remedies for Postcolonial Imbalance*. Durham: Duke University Press. 2002:114.

[8] As recently as 1990, more than 40 years after the Udupa report, the author encountered students at the Government Ayurveda Medical College in Bangalore who were on hunger strike demanding basic biomedical and emergency medicine courses added to the still "pure" Ayurvedic curriculum. While there are Ayurvedic medical colleges offering integrated medical training, Bangalore did not, somewhat of an anomaly for one of the fastest growing technological centers in the world. I subsequently learned that some Ayurvedic practitioners prescribed Western drugs, and that patients trusted them more than biomedical physicians. The cultural and social capital Ayurvedic practitioners have with the Indian rural and religious masses poses as much a threat to biomedical practitioners as it affords opportunities for political appropriation and exploitation.

[9] See Policies Towards Indian Systems of Medicine and Homeopathy After 1947. Reproduced from: Report on the Health Status of the Indian People. Bombay: FRCH, 1987. http://www.healthlibrary.com/reading/banyan1/1appen3.html. Accessed 05/27/04.

[10] See Patricia Jeffrey and Roger Jeffery 2002, concerning Hindu Right rhetorical claims about Hindu-Muslim differences in fertility behavior.

[11] Gramsci, as cited in Michael Adas, Contested Hegemony: The Great War and the Afro-Asian Assault on the Civilizing Mission Ideology. *Journal of World History* 15:1:36 (2004).

[12] See, LexisNexis(TM) Academic – SB577 Tracking.htm.

[13] Quarterly publications such as *Common Ground* and the monthly *Open Exchange* display a vast assortment of healing practices, practitioners, schools, centers, groups, and retreats.

[14] Karl Polanyi 1957. *The Great Transformation.* p.152).

APPENDIX

The following consists of the research questions developed for the purposes of conducting this ethnographic research. Intended for both structured and unstructured interviews, the practicalities of the project determined that the questions were posed in a semi-structured manner, which often occurred during break and meal times. This more relaxed format, preferred by most informants, was conducive to facilitating better communication.

Interview Protocols

1. Why did you choose to take this clinical Ayurvedic workshop for health care practitioners?
2. What area of health care do you work?
3. How do Ayurvedic approaches translate into your life and work?
4. Have the meanings of health, illness, and/or healing changed over your life? If so, how?
5. Could you draw a map of your life highlighting those moments when your concepts of health, illness, healing, the body, or diet changed significantly or began to shift in a certain direction.
6. What changes in awareness did you experience?
7. What course of action did you take?
8. Did your change of awareness and subsequent action take you outside the biomedical paradigm?
9. Could you describe your learning experience with Ayurvedic medicine?

10. As a Western student of Ayurveda, what Ayurvedic concepts or practices have challenged your cultural, social, intellectual, or spiritual values, or presumptions the most?

11. Conversely, what Ayurvedic concepts and practices have provided solutions to any cultural, social, intellectual, or spiritual issues or questions you could not find answers to from within your own culture?

12. Have you experienced cultural miscommunication in the teaching and learning of Ayurveda? Meaning, do differences in lifestyle, gender roles, or nutritional attitudes, sometimes create misunderstandings concerning how Ayurveda could best be applied in the local context - for example: Does "Ayurvedic Nutrition" = "Indian food?"

13. Charaka says that medicine works best if it is in a form culturally acceptable to the patient. What, if any, cultural reconfiguring have you done in order to successfully incorporate Ayurvedic practices into your personal and professional life?

14. Has Ayurveda given you a different means of understanding other healing systems? If so, how?

15. Is there anything you would like to add before we conclude?

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